Occupational Therapy Expert Opinions on Work Capacity: A Grounded Theory

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at The University of Queensland
in July 2005
The thesis concept and the work presented in this thesis are original. Any exceptions have been acknowledged in the references to published literature.

I declare that I have not submitted this material, either in whole or part, for a degree at this or any other university.

Shelley Allen

Dr. Tamara Ownsworth

Dr. Glenys Carlson

Professor Jenny Strong
ACKNOWLEDGEMENTS

My thesis is primarily dedicated to my husband, Richard Kieran Allen, who has been my constant advisor and companion for more than 35 years. He recognised the value of the thesis and challenged me to indulge my curiosity. When progress was slow and difficult, he encouraged me and made me laugh. My thesis is also dedicated to our children, Siobhan, Tim, Dominic and Rosie from whom I have learnt a lot about determination and commitment. Finally, my thesis is dedicated to my parents, Evan and Evelyn Doneley, who valued tertiary education.

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A research grant of $6,000 from the Occupational Therapy Board of Queensland in 2005 has enabled me to write a paper entitled “A framework for systematically improving occupational therapy medico-legal expert opinion on work capacity: Recommendations of occupational therapists, lawyers and medical specialists.”
LIST OF PUBLICATIONS AND PRESENTATIONS

Presentations by the Candidate Relevant to the Thesis


Additional Publications by the Candidate Relevant to the Thesis but not Forming Part of It


The provision of expert opinion for the medico-legal system has emerged as a specialised area of occupational therapy practice. There has been an increased demand for occupational therapists’ opinions on the functional implications of injuries in terms of work capacity and independent living for the purposes of litigation, compensation or insurance. The evaluation of work capacity has emerged as a challenging area of the medico-legal specialty requiring separate examination, and as such forms the basis of the present research. Occupational therapists with expertise in work rehabilitation are often asked to provide medico-legal reports on the work capacity of claimants with injuries for stakeholders with competing interests (e.g., plaintiff solicitors and insurance companies), and can be required to serve as expert witnesses before courts or tribunals. However, research to guide occupational therapists who assess work capacity in personal injury cases has not kept pace with the growth of this specialised area of practice.

Therefore, the research aims were (a) to understand the contribution of the occupational therapy profession to medico-legal decisions about work capacity, (b) to identify current occupational therapy medico-legal work capacity evaluation and expert witness practices, and (c) to identify strategies to improve occupational therapy expert opinions on work capacity.

Grounded theory methodology was used to collect and analyse data from 31 participants of whom 19 were occupational therapists, 6 were medical specialists and 6 were lawyers. Participants were selected by theoretical sampling. Focused semi-
structured interviews were completed with each participant, yielding almost 1000 pages of data. Interviews continued until data categories were saturated. The data were transcribed and systematically analysed with open, axial and selective coding.

Grounded theory data analysis was informed by Charmaz (2000, 2002), Glaser and Strauss (1967), Glaser (1978, 1992), and Strauss and Corbin (1990, 1998). Through a process of increasing abstraction, a grounded theory was identified as embedded in the data. The central concept which emerged from the data was that of expertise in work capacity. The grounded theory of expertise consisted of four sets of distinct but inter-related theoretical formulations. The grounded theory was returned to the participants as key findings, and these were verified by 20 participants.

The grounded theory of occupational therapy expertise in work capacity comprised four broad areas of expertise. These were as follows: (a) understanding the medico-legal system and relevant interactions with key stakeholders; (b) providing valued, credible and unbiased expert opinions that are within occupational therapy areas of expertise; (c) assessing, forming opinions and writing reports on work capacity; and (d) using strategies to remain current with the trends in the medico-legal system and to systematically improve expertise.

Within these key areas of expertise it was identified that occupational therapy opinions are of particular value when the legal and medical professions are unable to fully answer questions about work capacity in complex, ambiguous or disputed cases. Occupational therapy opinions are requested primarily for claimants with musculoskeletal conditions, and secondarily for clients with traumatic brain injury. The distinctive occupational therapy areas of expertise that assist the courts are the assessment of claimants’ functional work capacities, analysis and description of jobs,
and relating this information to past, present and potential jobs suitable for claimants.

An eclectic assessment approach combining different sources and types of information is most commonly used. To gain respect in the medico-legal system there are a number of strategies occupational therapists can use to establish credibility and reduce perceptions of bias. Participants recommended a number of general professional development strategies including the outline of a continuing education module, and workplace practices. In addition, they made specific recommendations for improving expert opinion through reporting and assessment practices. Ways of documenting professional reasoning to support expert opinions were addressed.

The research has several implications for occupational therapists working in the medico-legal specialty in Australia. In particular, the grounded theory of occupational therapy expertise in work capacity provides evidence-based professional guidance for occupational therapists in relation to professional practices, reasoning and decision-making. It is anticipated that such guidance will also enhance practice through providing support for professional development activities in this evolving and specialised area of practice. The present study is expected to stimulate further research on theories of expertise within other professional contexts.
TABLE OF CONTENTS

Declaration of Originality ................................................................. ii
Acknowledgements ........................................................................ iii
List of Publications and Presentations .......................................... iv
Abstract ......................................................................................... v
Table of Contents ........................................................................ viii
List of Tables and Figures ............................................................. xiv
Abbreviations Used in the Thesis ................................................ xvi

PART A: INTRODUCTION

CHAPTER 1: BACKGROUND TO THE THESIS
1.0 Impetus and Rationale for the Thesis 1
1.1 Preliminary Clarification of the Medico-Legal System and Terminology 1
1.2 The Development of Work-related Occupational Therapy Practices 6
1.3 Expert Opinions on Functional Capacity: Important Developments and the Nature of Occupational Therapy Contribution 8
1.4 Professional Recognition of the Need to Support Medico-legal Practice 10
1.5 The Problem: A Lack of Research into Expert Opinions on Work Capacity 11
1.6 The Extent of the Problem for Occupational Therapists 12
1.7 The Rationale for this Research 13
1.8 The Significance of the Research 15
1.9 Anticipated Benefits of Research into Occupational Therapy Expert Opinions on Work Capacity 16
1.10 Organisation of the Thesis 17
1.11 Summary and Conclusion 19

CHAPTER 2: PERSPECTIVES FROM THE LITERATURE REGARDING OCCUPATIONAL THERAPY MEDICO-LEGAL WORK CAPACITY SERVICES
2.0 Introduction 20

OCCUPATIONAL THERAPY MEDICO-LEGAL WORK CAPACITY SERVICES ................................................................. 21
2.1 Theoretical Perspectives Related to Medico-legal Opinions on Work Capacity 22
2.2 Research on Occupational Therapy Medico-legal Services 27
2.3 Professional Accounts of Occupational Therapy Medico-legal Services 29
2.4 Occupational Therapy Professional and Ethical Guidelines 40
2.5 Summary and Conclusion: Occupational Therapy Medico-legal Literature 43

WORK-RELATED ASSESSMENT ISSUES ........................................ 44
2.6 Potential Challenges for Experts Using Work-related Assessments 44
HEALTH PROFESSIONALS AS EXPERT WITNESSES……………………….. 52
2.7 Medico-legal Literature for Health Professionals 52
2.8 The Increased Use of Health Professionals as Expert Witnesses 53
2.9 Trends Impacting on Expert Witnesses 60
2.10 Expert Evidence and Expert Witnesses 61
2.11 Evidence and Expertise 66
2.12 Expert Witnesses and Claimants/Plaintiffs 69
2.13 Conclusions Regarding Perspectives from the Literature 72
2.14 Directions of Future Research 73
2.15 Research Aims and Research Questions 74

PART B: THE RESEARCH DESIGN AND PROCESS

CHAPTER 3: METHODOLOGY AND METHODS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>Introduction</td>
<td>76</td>
</tr>
<tr>
<td>3.1</td>
<td>The Qualitative Research Paradigm</td>
<td>76</td>
</tr>
<tr>
<td>3.2</td>
<td>Grounded Theory: Purpose and Development</td>
<td>78</td>
</tr>
<tr>
<td>3.3</td>
<td>Grounded Theory in Socially-focussed Disciplines</td>
<td>79</td>
</tr>
<tr>
<td>3.4</td>
<td>Grounded Theory Variants and Features</td>
<td>81</td>
</tr>
<tr>
<td>3.5</td>
<td>Data Collection</td>
<td>85</td>
</tr>
<tr>
<td>3.6</td>
<td>Data Analysis</td>
<td>93</td>
</tr>
<tr>
<td>3.7</td>
<td>Research Rigour</td>
<td>99</td>
</tr>
<tr>
<td>3.8</td>
<td>Summary: Methodology and Methods</td>
<td>104</td>
</tr>
</tbody>
</table>

CHAPTER 4: THE PARTICIPANTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>Introduction</td>
<td>105</td>
</tr>
<tr>
<td>4.1</td>
<td>Theoretical Sampling</td>
<td>105</td>
</tr>
<tr>
<td>4.2</td>
<td>Selection Criteria</td>
<td>106</td>
</tr>
<tr>
<td>4.3</td>
<td>The Recruitment Strategy</td>
<td>106</td>
</tr>
<tr>
<td>4.4</td>
<td>Description of the Participant Sample</td>
<td>110</td>
</tr>
<tr>
<td>4.5</td>
<td>Ethical Considerations Regarding Participants</td>
<td>115</td>
</tr>
<tr>
<td>4.6</td>
<td>Summary: The Participants</td>
<td>118</td>
</tr>
</tbody>
</table>

PART C: RESULTS AND DISCUSSION

CHAPTER 5: UNDERSTANDING THE MEDICO-LEGAL SYSTEM AND INTERACTIONS WITH STAKEHOLDERS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>Introduction</td>
<td>119</td>
</tr>
<tr>
<td>5.1</td>
<td>Medico-legal Concepts and Processes Related to Opinions on Work Capacity</td>
<td>120</td>
</tr>
<tr>
<td>5.2</td>
<td>Laws and Jurisdictions Relevant to Occupational Therapy Opinions</td>
<td>126</td>
</tr>
<tr>
<td>5.3</td>
<td>Metaphors for the Medico-legal System</td>
<td>129</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>5.4</td>
<td>Rehabilitation and Medico-legal Work Capacity Assessments</td>
<td>129</td>
</tr>
<tr>
<td>5.5</td>
<td>Assessments for Gratuitous Care and Assistance Claims</td>
<td>131</td>
</tr>
<tr>
<td>5.6</td>
<td>Summary and Discussion: Occupational Therapy in the Medico-legal System</td>
<td>132</td>
</tr>
<tr>
<td>5.7</td>
<td>STAKEHOLDERS: ROLES AND RELATIONSHIPS</td>
<td>135</td>
</tr>
<tr>
<td>5.8</td>
<td>The Role of Expert Witnesses/Experts and Their Evidence</td>
<td>135</td>
</tr>
<tr>
<td>5.9</td>
<td>Summary and Discussion: Expert Witnesses/Experts’ Roles and Evidence</td>
<td>139</td>
</tr>
<tr>
<td>5.10</td>
<td>Summary and Discussion: Professional and Personal Characteristics</td>
<td>145</td>
</tr>
<tr>
<td>5.11</td>
<td>Solicitors’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>146</td>
</tr>
<tr>
<td>5.12</td>
<td>Summary and Discussion: Solicitors’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>151</td>
</tr>
<tr>
<td>5.13</td>
<td>Summary and Discussion: Barristers’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>152</td>
</tr>
<tr>
<td>5.14</td>
<td>Summary and Discussion: Judges’, Commissioners’ and Magistrates’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>153</td>
</tr>
<tr>
<td>5.15</td>
<td>Summary and Discussion: Judges’, Commissioners’ and Magistrates’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>154</td>
</tr>
<tr>
<td>5.16</td>
<td>Summary and Discussion: Insurers’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>158</td>
</tr>
<tr>
<td>5.17</td>
<td>Summary and Discussion: Insurers’ Medico-Legal Roles and Interactions with Occupational Therapists</td>
<td>160</td>
</tr>
<tr>
<td>5.18</td>
<td>Medical Specialists: Lawyers’ Perspectives</td>
<td>161</td>
</tr>
<tr>
<td>5.19</td>
<td>Summary and Discussion: Lawyers’ Perspectives on Medical Specialists</td>
<td>163</td>
</tr>
<tr>
<td>5.20</td>
<td>Claimants in the Medico-Legal System</td>
<td>164</td>
</tr>
<tr>
<td>5.21</td>
<td>Summary and Discussion: Participants’ Perspectives of Claimants</td>
<td>172</td>
</tr>
<tr>
<td>5.22</td>
<td>Conclusion: Understanding the Medico-legal System and Interactions with Stakeholders</td>
<td>174</td>
</tr>
<tr>
<td>5.23</td>
<td>CHAPTER 6: IDENTIFYING THE OCCUPATIONAL THERAPY AREAS OF WORK CAPACITY EXPERTISE THAT ASSIST THE COURTS</td>
<td>176</td>
</tr>
<tr>
<td>6.0</td>
<td>Introduction</td>
<td>177</td>
</tr>
<tr>
<td>6.1</td>
<td>PROVIDING VALUED OCCUPATIONAL THERAPY EXPERT OPINIONS…</td>
<td>177</td>
</tr>
<tr>
<td>6.2</td>
<td>The Contribution of “Pioneers”</td>
<td>178</td>
</tr>
<tr>
<td>6.3</td>
<td>Current Contribution of Occupational Therapy Experts on Work Capacity</td>
<td>178</td>
</tr>
<tr>
<td>6.4</td>
<td>Summary and Discussion: The Value of Occupational Therapists’ Contribution to Medico-legal Decisions about Work Capacity</td>
<td>184</td>
</tr>
<tr>
<td>6.5</td>
<td>IDENTIFYING OCCUPATIONAL THERAPISTS’ AREAS OF EXPERTISE…</td>
<td>186</td>
</tr>
<tr>
<td>6.6</td>
<td>Occupational Therapists’ Perspectives: Areas of Expertise</td>
<td>186</td>
</tr>
<tr>
<td>6.7</td>
<td>Lawyers’ Perspectives: Occupational Therapy Areas of Expertise</td>
<td>194</td>
</tr>
<tr>
<td>6.8</td>
<td>Medical Perspectives: Areas of Occupational Therapy Expertise</td>
<td>197</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>6.7</td>
<td>Summary and Discussion: Occupational Therapists’ Areas of Expertise</td>
<td>200</td>
</tr>
<tr>
<td>6.8</td>
<td>Comparing Occupational Therapists’ Expertise with that of</td>
<td>205</td>
</tr>
<tr>
<td></td>
<td>Other Experts</td>
<td></td>
</tr>
<tr>
<td>6.9</td>
<td>Summary and Discussion: Comparison of Professional Expertise</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td><strong>PROVIDING CREDIBLE AND UNBIASED OCCUPATIONAL THERAPY OPINIONS ON WORK CAPACITY</strong></td>
<td>213</td>
</tr>
<tr>
<td>6.10</td>
<td>Credibility</td>
<td>213</td>
</tr>
<tr>
<td>6.11</td>
<td>Bias and Credibility</td>
<td>225</td>
</tr>
<tr>
<td>6.12</td>
<td>Summary and Discussion: Providing Credible and Unbiased</td>
<td>228</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Opinions</td>
<td></td>
</tr>
<tr>
<td>6.13</td>
<td>Conclusion: Identifying Occupational Therapy Areas of Expertise</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td>in Work Capacity that Assist the Courts</td>
<td></td>
</tr>
<tr>
<td>7.0</td>
<td><strong>CHAPTER 7: ASSESSING WORK CAPACITY, AND FORMING AND REPORTING OPINIONS ON WORK CAPACITY</strong></td>
<td>232</td>
</tr>
<tr>
<td>7.1</td>
<td>Overview of Participants’ Perspectives on Work Capacity Assessments</td>
<td>233</td>
</tr>
<tr>
<td>7.2</td>
<td>Standardised Marketed Assessments: Occupational Therapy Perspectives</td>
<td>233</td>
</tr>
<tr>
<td>7.3</td>
<td>Standardised Assessments: Medical Specialists’ Perspectives</td>
<td>235</td>
</tr>
<tr>
<td>7.4</td>
<td>Non-standardised Assessments: Occupational Therapy Perspectives</td>
<td>241</td>
</tr>
<tr>
<td>7.5</td>
<td>Non-standardised Assessments: Medical Specialists’ Perspectives</td>
<td>242</td>
</tr>
<tr>
<td>7.6</td>
<td>Eclectic or Combined Assessments</td>
<td>245</td>
</tr>
<tr>
<td>7.7</td>
<td>Summary and Discussion: Work Capacity Assessments</td>
<td>246</td>
</tr>
<tr>
<td>7.8</td>
<td>Assessing Psychosocial Factors: Occupational Therapists’ Perspectives</td>
<td>258</td>
</tr>
<tr>
<td>7.9</td>
<td>Psychosocial Factors: Legal Practitioners’ Perspectives</td>
<td>264</td>
</tr>
<tr>
<td>7.10</td>
<td>Psychosocial Factors: Medical Specialists’ Perspectives</td>
<td>269</td>
</tr>
<tr>
<td>7.11</td>
<td>Summary and Discussion: Opinions on Psychosocial Factors</td>
<td>271</td>
</tr>
<tr>
<td>7.12</td>
<td>Other Work-related Assessments</td>
<td>273</td>
</tr>
<tr>
<td>7.13</td>
<td>Summary and Discussion: Other Assessments</td>
<td>276</td>
</tr>
<tr>
<td>7.14</td>
<td><strong>INTERPRETING FINDINGS, AND FORMING AND REPORTING OPINIONS</strong></td>
<td>280</td>
</tr>
<tr>
<td>7.15</td>
<td>Medico-legal Work Capacity Reports: Occupational Therapists’</td>
<td>282</td>
</tr>
<tr>
<td></td>
<td>Perspectives</td>
<td></td>
</tr>
<tr>
<td>7.16</td>
<td>Medico-legal Work Capacity Reports: Legal Practitioners’ Perspectives</td>
<td>282</td>
</tr>
<tr>
<td>7.17</td>
<td>Medico-legal Work Capacity Reports: Medical Specialists’ Perspectives</td>
<td>295</td>
</tr>
<tr>
<td>7.18</td>
<td>Summary and Discussion: Forming Opinions and Writing Reports</td>
<td>298</td>
</tr>
<tr>
<td></td>
<td>Conclusion: Occupational Therapy Methods of Assessing,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forming Opinions and Writing Reports on Work Capacity</td>
<td>302</td>
</tr>
<tr>
<td></td>
<td>in Personal Injury Cases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conclusion: Identifying Occupational Therapy Areas of Expertise</td>
<td>305</td>
</tr>
<tr>
<td></td>
<td>in Work Capacity that Assist the Courts</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 8: SYSTEMATICALLY IMPROVING OCCUPATIONAL THERAPY EXPERT OPINIONS ON WORK CAPACITY

8.0 Introduction 307

TRENDS IMPACTING ON OCCUPATIONAL THERAPY EXPERT OPINIONS ON WORK CAPACITY 308
8.1 Overview of Trends in the Medico-legal System 308
8.2 Trends Influencing Occupational Therapy Work Capacity Opinions 308
8.3 Summary and Discussion: Trends Impacting on Occupational Therapists 313

PROFESSIONAL DEVELOPMENT STRATEGIES 318
8.4 Years and Type of Experience: Occupational Therapists’ Perspectives 318
8.5 Effective Workplace Practices: Occupational Therapists’ Perspectives 320
8.6 Continuing Professional and Tertiary Education: Participants’ Perspectives 321
8.7 The Role of Professional Organisations: Participants’ Perspectives 326
8.8 Self-Development Strategies: Occupational Therapists’ Perspectives 328
8.9 Professional Development Resources: Participants’ Perspectives 329
8.10 Summary and Discussion: Professional Development Strategies 330

STRATEGIES FOR DEVELOPING EXPERT OPINIONS THROUGH ASSESSMENT AND REPORTING PRACTICES 333
8.11 Improving Opinions through Assessment and Reporting Practices: Participants’ Perspectives 333
8.12 Summary and Discussion: Participants’ Strategies for Developing Expert Opinions through Assessment and Reporting Practices 352
8.13 Conclusion: Systematically Improving Occupational Therapy Expert Opinions on Work Capacity 356

PART D: RESEARCH CONCLUSIONS, CONTRIBUTIONS AND IMPLICATIONS

CHAPTER 9: IDENTIFICATION OF A GROUNDED THEORY OF OCCUPATIONAL THERAPY EXPERTISE IN WORK CAPACITY

9.0 Introduction 357
9.1 Occupational Therapy Expertise in Work Capacity: Understanding the Medico-legal System and Interactions with Key Stakeholders 361
9.2 Occupational Therapy Expertise in Work Capacity: Areas of Occupational Therapy Expertise that Assist the Courts 365
9.3 Occupational Therapy Expertise in Methods of Assessing, Forming Opinions and Reporting on Work Capacity in Personal Injury Cases 366
9.4 Systematically Improving Occupational Therapy Expertise in Work Capacity 372
9.5 Conclusion: The Grounded Theory of Occupational Therapy Expertise in Work Capacity 375
CHAPTER 10: THE RESEARCH CONTRIBUTIONS AND IMPLICATIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.0</td>
<td>Introduction</td>
<td>377</td>
</tr>
<tr>
<td>10.1</td>
<td>Addressing the Research Aims and Questions</td>
<td>377</td>
</tr>
<tr>
<td>10.2</td>
<td>The Significance of the Research Contributions</td>
<td>381</td>
</tr>
<tr>
<td>10.3</td>
<td>Research Limitations and Methodological Considerations</td>
<td>388</td>
</tr>
<tr>
<td>10.4</td>
<td>Implications for the Occupational Therapy Medico-legal Specialty:</td>
<td>394</td>
</tr>
<tr>
<td></td>
<td>Understanding and Developing Expertise</td>
<td></td>
</tr>
<tr>
<td>10.5</td>
<td>Recommendations for Further Research</td>
<td>396</td>
</tr>
<tr>
<td>10.6</td>
<td>Final Comment</td>
<td>398</td>
</tr>
</tbody>
</table>

REFERENCES........................................................................................................ 399

APPENDICES

A Glossary of Medico-legal and Professional Terms
B Participant Information Sheet
C Informed Consent Form
D Gate Keeper Letter
E Interview Guide for Participant Occupational Therapists
F Interview Guide for Participant Medical and Legal Professionals
G Pro forma for Part 1 of In-depth Interviews
H List of Open Codes
I List of Participants’ Pseudonyms according to their Professions
J Participant Verification Package including Key Findings
   J1 Letter dated February 17, 2004
   J2 Letter dated January, 5 2005
   J3 Questions for Participants about Key Findings
   J4 Overview of the Contribution of Occupational Therapists
      to Medico-legal Decisions about Work Capacity
   J5 Four Clusters of Key Findings
K Sample FCE Format based on the Dictionary of Occupational Titles (1991b)
## LIST OF TABLES AND FIGURES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Systematic Search Strategies</td>
<td>22</td>
</tr>
<tr>
<td>Table 2</td>
<td>Features of Grounded Theory Used in the Current Research</td>
<td>84</td>
</tr>
<tr>
<td>Table 3</td>
<td>Summary of Interviews with Participants: Settings, Methods and Duration</td>
<td>88</td>
</tr>
<tr>
<td>Table 4</td>
<td>Details of Recruitment Methods Employed for each Participant Group</td>
<td>110</td>
</tr>
<tr>
<td>Table 5</td>
<td>Summary of Participants’ Demographic and Employment Characteristics</td>
<td>112</td>
</tr>
<tr>
<td>Table 6</td>
<td>Details of Participants’ Medico-legal Practices</td>
<td>114</td>
</tr>
<tr>
<td>Table 7</td>
<td>Patterns that Occupational Therapists Associated with Reporting for the Plaintiff or the Defendant</td>
<td>124</td>
</tr>
<tr>
<td>Table 8</td>
<td>Jurisdictions Utilising Occupational Therapists’ Work-related Opinions</td>
<td>127</td>
</tr>
<tr>
<td>Table 9</td>
<td>Experiences of Occupational Therapists in Queensland Supreme and District Courts</td>
<td>128</td>
</tr>
<tr>
<td>Table 10</td>
<td>Comparison of Medico-legal Assessments and Rehabilitation</td>
<td>130</td>
</tr>
<tr>
<td>Table 11</td>
<td>Participants’ Perspectives of the Expert Witness Role</td>
<td>136-137</td>
</tr>
<tr>
<td>Table 12</td>
<td>Stressful Situations for Occupational Therapy Expert Witnesses</td>
<td>142</td>
</tr>
<tr>
<td>Table 13</td>
<td>Factors Increasing the Confidence of Occupational Therapy Expert Witnesses</td>
<td>144</td>
</tr>
<tr>
<td>Table 14</td>
<td>Occupational Therapists’ and Lawyers’ Perceptions of the Role of Judges</td>
<td>155</td>
</tr>
<tr>
<td>Table 15</td>
<td>Lawyers Perspectives on Plaintiffs</td>
<td>168</td>
</tr>
<tr>
<td>Table 16</td>
<td>Work-related Opinions Requested of Occupational Therapists</td>
<td>187</td>
</tr>
</tbody>
</table>
Table 17  Resources Used by Occupational Therapists to Increase Claimants’ Employability  
Table 18  Specialist Areas of Occupational Therapy Expertise  
Table 19  Medical Specialists’ Perceptions of Occupational Therapy Areas of Expertise  
Table 20  Comparing Medical Specialists’ and Occupational Therapists’ Areas of Expertise  
Table 21  Comparison of Physiotherapy and Occupational Therapy Expertise: Occupational Therapists’ Perspectives  
Table 22  Work Experience adding to Occupational Therapists’ Credibility  
Table 23  Competencies that Increase the Credibility of Occupational Therapy Experts on Work Capacity  
Table 24  Perceived Sources of Bias Influencing Occupational Therapy Opinions  
Table 25  Strategies to Reduce Perceptions of Bias in Occupational Therapy Opinions  
Table 26  Limitations of Standardised FCEs as Experienced by Occupational Therapists  
Table 27  Sophie’s Eclectic FCE “based on the Isernhagen model.”  
Table 28  Advantages of Assessing Claimants in their Workplace  
Table 29  Reasons for Limited Access to Workplaces: Occupational Therapists’ Experiences  
Table 30  Psychosocial Factors Occupational Therapists Assess for the Impact on Work Capacity  
Table 31  Challenges for Occupational Therapists in Forming Opinions on Work Capacity  
Table 32  Characteristics of Good Occupational Therapy Medico-Legal Opinions: Occupational Therapists’ Perspectives  
Table 33  Categories of Occupational Therapy Work-related Recommendations  
Table 34  Considerations for Making Recommendations in Occupational Therapy Experts’ Reports
Note. A dash in a table indicates that a statement was not applicable to a group of participants.
Figure 1  Overview: Grounded Theory of Occupational Therapy Expertise in Work Capacity  360
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>AOTA</td>
<td>American Occupational Therapy Association</td>
</tr>
<tr>
<td>CAOT</td>
<td>Canadian Association of Occupational Therapists</td>
</tr>
<tr>
<td>Comp/compo</td>
<td>Compensation (e.g., Workers Comp’s)</td>
</tr>
<tr>
<td>CTP</td>
<td>Compulsory Third Party (Insurance)</td>
</tr>
<tr>
<td>CV</td>
<td>Curriculum Vitae</td>
</tr>
<tr>
<td>DOT</td>
<td>Dictionary of Occupational Titles</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence-based Practice</td>
</tr>
<tr>
<td>FCE</td>
<td>Functional Capacity Evaluation</td>
</tr>
<tr>
<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
</tr>
<tr>
<td>L</td>
<td>Lawyer</td>
</tr>
<tr>
<td>M</td>
<td>Medical Specialist</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>O*Net</td>
<td>Occupational Information Network</td>
</tr>
<tr>
<td>OT/OTs</td>
<td>Occupational Therapist/s</td>
</tr>
<tr>
<td>QC</td>
<td>Queen’s Counsel</td>
</tr>
<tr>
<td>RTW</td>
<td>Return to Work</td>
</tr>
<tr>
<td>SC</td>
<td>Senior Counsel</td>
</tr>
<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>U.K.</td>
<td>United Kingdom of Great Britain and Northern Ireland</td>
</tr>
<tr>
<td>U.S.</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>

Please Note: A Glossary of Medico-legal Terms and Professional Terms related to this thesis are in Appendix A.
CHAPTER 1

BACKGROUND TO THE THESIS

1.0 Impetus and Rationale for the Thesis

This introductory chapter will relate the research topic to the medico-legal system, and then focus on the impetus and rationale for the thesis. The impetus will be related to two developments within the occupational therapy profession, namely, the development of work-related practices as a specialised area of occupational therapy practice, and the increased demand within the medico-legal system for occupational therapists’ expert opinions on the residual work capacity of people with injuries. Following an outline of these two developments, the need for research to inform occupational therapists about their role as experts on the work capacity of personal injury claimants will be identified along with the rationale for the present research. The chapter will conclude with an outline of the thesis chapters.

1.1 Preliminary Clarification of the Medico-Legal System and Terminology

An occupational therapy expert opinion on the residual work capacity of a person with an injury (i.e., plaintiff or claimant) is initially provided as a written report in response to a request from the plaintiff solicitor or defendant solicitor. The former represents the claimant, while the latter represents the employer or insurer. The report consists of assessment findings and an opinion about the person’s work capacity including recommendations for increasing his/her employability. Employability refers
to the claimant having the work capacity to participate in paid employment, despite impairment. An expert may later be subpoenaed and examined, that is, questioned about the opinion as an expert witness before a court or a tribunal (Occupational Therapy Australia - New South Wales, 1998).

“Medico-legal” is the term commonly used by occupational therapists to identify that they are “independent” experts who provide services for the civil law system and in this way distinguish the role from a “treating” rehabilitation professional role (Occupational Therapy Australia - New South Wales, 1998). In this thesis “medico-legal” is the general term that refers to the civil law system in which personal injury claims may proceed to litigation in a court of law. Most commonly, a solicitor or an insurer requests an occupational therapy medico-legal expert opinion for a claimant/plaintiff who has received injuries through work, a motor vehicle accident or an incident in a public place (Cockburn, 2004).

“Personal injury claim” is another term commonly used in the medico-legal system. Personal injury claims may be considered in relation to two sources of civil law. The first source is the legislative provisions of Acts or statutes passed by Australian state and federal governments, while the second source is the legal principle of common law (Forrester & Griffiths, 2001). Personal injury claims may arise from work-related statutes and jurisdictions such as those associated with workers’ compensation, compulsory third-party motor vehicle insurance, medical negligence, public and product liability, and appeals against government administrative decisions (Braithwaite, 1997; Occupational Therapy Australia - New South Wales, 1998).

Injuries that are attributable, wholly or partly, to the fault of another person or persons may be the subject of personal injury compensation claims (Braithwaite, 1997). In some countries, including Australia, United Kingdom (U.K.) and Canada, claims for compensation of economic loss, and pain and suffering may be dealt with in adversarial
proceedings in courts of law (Breen, Plueckhahn, & Cordner, 1997). Although a large majority of claims settle out of court by negotiation or compulsory conference, some proceed to a hearing or trial (Purse, 2000). In Australia, according to the monetary value of compensation sought, personal injury matters may be heard in one of a hierarchy of courts including the Supreme Court which is a “superior” court, or District/County Courts which are courts of “intermediate” jurisdiction (Breen et al., 1997; Forrester & Griffiths, 2001). Some hearings may be held in “lower” or “minor” courts (e.g., tribunals) where complaints against decisions of government bodies are heard in a less formal, quasi-judicial setting (Breen et al., 1997). Judgements regarding personal injury claims in these three levels of federal or state jurisdiction are handed down by a judge or commissioner without a jury.

After a determination of the defendant’s liability for the injury, the quantum, that is, the amount of monetary compensation due to the plaintiff is calculated. Occupational therapists’ reports on personal injury claimants may contribute to the settlement of disputed cases between the plaintiff and defendant about quantum, through litigation (Sterry, 1998). The adversarial nature of litigation in countries such as the U.K., United States of America (U.S.) and Australia means that occupational therapists opinions may be in disagreement with those of other parties in the dispute (Sterry, 1998). The quantum is commonly dealt with under various categories of damages representing areas of loss. Damages can be divided into specific and general damages (Forrester & Griffiths, 2001). Specific damages are costs that have been incurred by the claimant such as lost wages. General damages are estimates of costs that will be incurred in the future as a result of the injury. General damages may include future economic loss, pain and suffering, loss of enjoyment of life, and anticipated medical, rehabilitation and care costs (Forrester & Griffiths, 2001). Occupational therapists’ reports may address a number of areas of general and specific damages.
relating to a person’s independent living and work capacity. Future economic loss is the
projected and reasonable loss of earnings attributed to the injury. Future economic loss
is the most expensive head (i.e., category) of damages in high awards and consequently
is often the subject of “protracted hard bargaining” (Cornes, 1997, p. 366).

Socio-political influences impact on medico-legal claims. Specifically, although
compensation of workers for injury has traditionally been a principal area of common
law that has provision for expert witnesses, legislation limiting the access of workers
with compensation claims to common law has been part of a socio-political trend to cut
the costs of workers’ compensation insurance for employers (Purse, 2000). Despite this
trend to reduce access to common law and, simultaneously, to increase statutory
compensation and rehabilitation in Australia, a number of workers’ compensation
schemes have retained access to this legal process (Bohle & Quinlan, 2000; O’Donnell,
2000; Purse, 2000). Similarly, access to common law by injured workers has been
substantially curtailed in some schemes in Canada and the U.S. by the introduction of
compulsory workers’ compensation legislation (Bohle & Quinlan, 2000). However,
Mark (2001) noted a growth in other areas for which members of society may seek
damages arising from accident or injury. For example, the Motor Accident Insurance
Act (MAIA) (1994) of Queensland, Australia, is one exception to the trend away from
access to common law.

A further area of litigation subject to socio-political influences arises from pre-
work medical screening of prospective employees in Australia, the U.S. and the U.K. In
undertaking these screenings, employers and assessors need to be aware of potential
discrimination against injured workers attempting to re-enter the workforce under
legislation such as the Disability Discrimination Act (Commonwealth) (1992) and the
Anti-discrimination Act (Queensland) (1991) in Australia, the Americans with
Discrimination Act (DDA) (1995) in the U.K. If a worker is able to perform the essential or inherent requirements of the job, employers are expected to provide necessary support, services and modifications, unless to do so would cause them unreasonable financial hardship. The introduction of the ADA (U.S. Congress, 1990) has enabled workers with disabilities to have their complaints of work-related discrimination heard in the U.S. Federal courts (Huang & Feuerstein, 1998). Of these claims, musculoskeletal injuries are the largest group of impairments (Huang & Feuerstein, 1998). The DDA in the U.K. has had a similar effect (Pratt, 1997). In the context of this legislation, employers must balance anti-discrimination obligations with obligations under relevant workplace health and safety legislation. L. L. Perry (1998) attributed the increased focus on job specific and valid functional assessments to the requirements of the ADA. Occupational therapists may be involved in conducting pre-work screening or attempts made by employers to prevent disputes entering the litigation stage.

Personal injury litigation, therefore, is a contentious issue in many areas of the community. Workers’ compensation litigation has sparked political debate over the rights of injured workers versus the costs of compensation to the Australian community (O’Donnell, 2000; Purse, 2000). Challenges to the high economic and social costs of public liability litigation have lead to regulation by governments in Australia (Luntz, 2004). Medical negligence is another contentious area of claims for which legislation such as the Civil Liability Act (2003) has been introduced. The medico-legal system needs to find a balance between compensating the plaintiff for their “incalculable” losses and “unacceptably high awards” (Braithwaite, 1997, p. 3).

It is in this socio-political context that occupational therapists provide expert opinions to the medico-legal system. These opinions may relate to work capacity and independent living. However, this thesis will specifically examine the contribution of
occupational therapists’ expert opinions on work capacity of claimants in the medico-
legal system.

The reader is referred to the Glossary of Medico-legal and Professional Terms
for an explanation of terms used in this thesis (see Appendix A). Some frequently used
terms such as “expert witness” are examined more fully in the literature review (see
Chapter 2); while frequently used abbreviations are explained on page xviii.

1.2 The Development of Work-related Occupational Therapy Practices

Occupational therapists’ expert opinions on work capacity have developed, in
part, from the profession’s role in the rehabilitation of injured and disabled workers.
From the mid-1930s occupational therapists have been recognised as providing
activity-based rehabilitation for injured workers. This expertise base has enabled them
to develop a “realistic gauge for evaluating the abilities of disabled workers to return to
work” (M. Kennedy, 1986, p. 354). Since the 1940s occupational therapists in Australia
have been employed to assist in the Commonwealth government’s vocational programs
for people with disabilities (O’Halloran, 2002). By the 1980s, the occupational therapy
contribution to the rehabilitation of injured workers in the community, including
workplaces, had been consolidated and documented internationally (deRenne-Stephan,
1985; Holmes, 1985; Innes, 1988; Jacobs, 1985). In 1986, the American Occupational
Therapy Association (AOTA) established a Work Programs Special Interest Section
(Jacobs, 1991b), confirming its commitment to furthering work-related occupational
therapy practice. Opportunities for occupational therapy work-related services in both
public and private sectors were facilitated by work-related legislation introduced in
Canada, Australia, the U.S. and the U.K. between the 1980s and 1990s (Pratt, 1996). In
the current decade, Joss (2002) stated that occupational therapists, through their
education and training, are well trained to understand the relationship between an
injured person’s medical condition, functional abilities, psychosocial status and work demands.

Contemporary work-related practices of occupational therapists have expanded to include a continuum of services from work injury prevention and ergonomic consultation services to return-to-work assessment and intervention services for unemployed people with an injury or disability (Burt, 2001; Fenton, Gagnon, & Pitts, 2003; Jacobs, 1999; Jundt & King, 1999; Pohlman, Poosawtsee, Gerndt, & Lindstrom-Hazel, 2001; Stuckey, 1997). In addition, occupational therapists provide case management for people accessing vocational rehabilitation and return-to-work programs (AOTA, 2000; O’Halloran, 2002). Several authors identified that occupational therapists provide some or all of the following work-related services: on-site job analysis, physical work tolerance baseline, work/functional capacity evaluation, work hardening, work conditioning, vocational exploration, vocational retraining, job placement, and on-site supervision of return-to-work programs (Burt, 2001; Deen, Gibson, & Strong, 2000; Helm, Powell, & Nieuwenhuijsen, 1999; Jundt & King, 1999; Lo, 2000; Pohlman et al., 2001; V. J. Rice & Luster, 2002).

Since the 1990s, occupational therapists have begun to align their work-related roles and services with their professional philosophy and conceptual models. For instance, the client-centred philosophy of the profession, recognised by the Canadian Association of Occupational Therapists (CAOT) (1997) and Christiansen and Baum (1997), has been applied to ergonomic services (S. Strong & Shaw, 1999). Similarly, occupational therapy conceptual models have been applied to work rehabilitation. Jeong (1996) described the occupational therapy role in work rehabilitation as follows: “We may adapt work tasks (the activity), work practices, environments (physical and interpersonal), coping strategies, and behaviors” (p. 41). This role, concerned with work tasks, worker, and workplace, directly corresponds to the many occupational
therapy conceptual models that emphasise congruence between the person, task and environment such as the Person-Environment-Occupation Model (Law et al., 1996) and Person-Environment-Occupational performance model (Christiansen & Baum, 1991, 1997). Such conceptual models support and inform occupational therapists’ role in work rehabilitation but appear to offer only limited guidance for assessment or reporting on work capacity in the medico-legal system. Conceptual models or theories that closely represent the features and requirements of the medico-legal specialty are needed to aid occupational therapy practitioners by providing explicit guidance regarding appropriate assessments, interpretations and recommended interventions, on which to base their expert opinions.

1.3 Expert Opinions on Functional Capacity: Important Developments and the Nature of Occupational Therapy Contribution

Internationally, since the 1980s there has been an increased demand for occupational therapists’ opinions on the functional implications of injuries in terms of work capacity and independent living for the purposes of litigation, compensation or insurance (Brangam, 1987; DeMaio-Feldman, 1987; Morgan, 1999; Occupational Therapy Australia - New South Wales, 1998; Sterry, 1998). Comprehensive occupational therapy reports on functional capacity may include assessment findings concerning the nature of the impairment, the functional impact of the injury on life tasks such as self-care, leisure, productivity (both paid and unpaid work), the impact on the injured person’s family, and rehabilitation recommendations (L. Kennedy, 1997a). An occupational therapist’s report on the person’s functional abilities at home, work and leisure, together with those of other experts, contribute to decisions about the economic losses, or damages, for which the person is compensated (Occupational Therapy Australia - New South Wales, 1998).
Occupational therapists began to attend courts of law as expert witnesses on functional capacity in the 1980s in Australia [Ralda Bourne, personal communication, 2003], the U.S. (DeMaio-Feldman, 1987), Canada (L. Kennedy, 1997a), and the U.K. (Sterry, 1998). Over the last three decades, the role of occupational therapy expert witnesses on functional capacity has become established in South Australia to the extent that an increasing number of barristers and solicitors regard an occupational therapy report as a “crucial document” in their preparation of a case for court (Morgan, 1999, p. 17). Morgan (1999) asserted that the provision of occupational therapy reports for court hearings “has increased significantly in South Australia in recent years” as barristers and solicitors have become “more aware of the contribution that occupational therapists can make” (p. 17).

This apparent appreciation of occupational therapy functional capacity reports by members of the legal professions may reflect the financial implications of the settlements. Settlements in some personal injury cases reported in the media have exceeded a million dollars (Luntz, 2004). Occupational therapists have an established role in providing opinions that contribute to decisions made about the cost of future care needs of persons with serious injuries (Harris, Henry, Green, & Dodson, 1994; L. Kennedy, 1997b). Consequently, the financial implications of court cases place the individuals who assume this role and the profession they represent under rigorous scrutiny by the stakeholders in the process.

A literature review on occupational therapy expert opinions indicated an increased demand for occupational therapists to assess a person’s functional capacity to independently undertake the full range of daily living activities. In particular, activities of daily living (ADL) assessments can be used to calculate the essential gratuitous care and assistance given by family or friends to a claimant in the past, present and future, for which they may be compensated under Griffiths v. Kerkemeyer (1977) claims.
(Cockburn, 2004). In addition, there are some international indicators of an increased demand for expert opinions that focus on work capacity as a separate area of function along with an indication of the value of those opinions (Lo, 2000; Occupational Therapy Australia – Queensland, n.d.; Pratt, 1996; Shriver, 1985).

Occupational therapy reports that focus on a claimant’s work capacity may be requested as part of the evidence used in adversarial medico-legal proceedings that decide a person’s employability, level of economic loss and compensation due to loss of work capacity. An expert’s opinion regarding a person’s capacity, or incapacity, for work can have a profound impact on the economic loss attributed to the injury across several decades and, thus, the resulting settlement. Therefore, there is a need for expert opinions on work capacity to be considered as a separate entity to other areas of occupational practice (e.g., medico-legal ADL assessments) and for specific guidelines for decision-making and professional practices to be identified for occupational therapists providing this service. The focus of this research is occupational therapists’ contribution to medico-legal decisions regarding work capacity of personal injury claimants, and increasing the availability of research-based professional guidance to support this evolving and specialised area of practice.

1.4 Professional Recognition of the Need to Support Medico-legal Practice

Professional activities, such as identifying and maintaining standards with respect to medico-legal practice, are one of the concerns of the national occupational therapy professional association, Occupational Therapy Australia. Occupational Therapy Australia - New South Wales (1998) has prepared practice guidelines for occupational therapists undertaking medico-legal assessments and reports. The professional association has also supported workshops and seminars to assist occupational therapists by explaining the medico-legal processes, providing advice to
improve report writing and expert witness skills, and generally aiming to build confidence to undertake this work. For example, occupational therapists, experienced in providing expert opinions, such as French and Roberts (1997) and French (2003), have provided medico-legal workshops at Australian occupational therapy conferences. McCluskey (2004) presented at personal injury conferences on the evidence base of accommodation options for people with catastrophic injuries. However, these existing practice guidelines have a general application to occupational therapy medico-legal assessment and reporting on adults and children, with a particular focus on independent personal care and domestic lifestyle. They lack specific occupational therapy guidelines for the provision of expert opinions on work capacity.

An initiative of the Occupational Therapists’ Board of Queensland further indicates the occupational therapy profession’s concern with improving expert witness standards for medico-legal practitioners (Occupational Therapy Australia - Queensland, 2001a, 2002). This Board, which has legal responsibility for registration of occupational therapists in Queensland, established a working party to address the issue of medico-legal reporting guidelines including criteria for experts involved in providing medico-legal assessments and reports for both adults and children. Consequently, a systematic study of the issues for occupational therapists conducting work capacity assessments for personal injury claimants would provide evidence-based information for enhancing occupational therapy practice, and in doing so, support the initiatives of the Occupational Therapists’ Board of Queensland.

1.5 The Problem: A Lack of Research into Expert Opinions on Work Capacity

Being acknowledged by the legal, health and rehabilitation professions as a profession that provides expert opinions on work capacity raises the profile of occupational therapy and gives further credibility to its role in work-related practices.
However, the understanding of occupational therapists regarding their contribution as experts on work capacity is currently limited by a lack of research on the topic. Furthermore, there are impediments to occupational therapy practitioners finding out about and improving professional practice in relation to expert opinions on work capacity. Currently, there is no clear avenue for occupational therapists to collectively gain genuine and direct feedback from referrers and readers of their medico-legal reports on work capacity. In particular, it can be difficult for “independent” experts in an adversarial medico-legal system to share practice experiences with one another, for ethical, competitive and practical reasons. Therefore, it is difficult for practising occupational therapists to gain a comprehensive overview of the medico-legal specialty including the value and limitations of their professional contribution and current practice standards.

As will be discussed in more detail in the literature review (see Chapter 2), despite the established role of occupational therapists in work-related practices and the relatively recent provision of expert opinions on work capacity, no known evaluative research on the contribution of occupational therapists to medico-legal decisions about work capacity has been conducted. The generation of information to guide occupational therapy medico-legal practitioners has not kept pace with the rapid expansion in this specialty area of practice.

1.6 The Extent of the Problem for Occupational Therapists

While it is difficult to estimate how many occupational therapists provide medico-legal work capacity reports and what proportion of their practice can be categorised as medico-legal, some indications are available. Depending on the source, statistics vary somewhat. Calculations based on “Who’s Working Where 2001,” a publication of the Occupational Therapy Australia - Queensland (2001b), suggest that
of the 255 private practitioners listed, a total of 40 (i.e., almost 16.6%) accepted medico-legal referrals. Of the 40, three provided medico-legal services only. A second survey about work-related practices in Australia suggested that, of the occupational therapists in work-related practices who returned their surveys \((n = 125)\), approximately half (48%) undertook medico-legal assessments (Deen et al., 2002). Superficially, Deen et al.’s data are not consistent with the data reported by Australian Institute of Health and Welfare (AIHW) (1998) in its national survey of the occupational therapy labour force. The AIHW’s survey reported that medico-legal work was the “principal diagnostic category” for only seven or 0.2% of employed clinical occupational therapists \((n = 2,298)\) in those Australian states included in the survey. However, occupational therapists from three Australian states, including the most populous state, New South Wales, were not surveyed, and occupational therapists who did respond were limited to one principal diagnostic category in their responses. It is likely that the 4.5% of occupational therapists who recorded “occupational health and safety” as their principal diagnostic category included occupational therapists for whom medico-legal assessment was a secondary or tertiary focus of their practice, thus, producing an underestimate of the extent of occupational therapists’ involvement in the medico-legal specialty.

1.7 The Rationale for this Research

The recognition of the need for the research developed out of the researcher’s involvement in work rehabilitation of injured workers, participation in working parties on Functional Capacity Evaluation (FCE), and an interest in the developing role of occupational therapists as expert witnesses on work capacity. Many questions about the nature of expert opinions on work capacity could not be answered satisfactorily from personal experience or the literature. The need for the research was first evident to the
researcher when in sole private practice undertaking medico-legal assessments and attending court as an expert witness between 1988 and 1992. Subsequently, the need became further evident to the researcher during a decade of providing continuing professional education, tertiary education and mentoring to occupational therapists engaged in work-related practices. All these experiences, especially the requests from post-graduate occupational therapists about how to respond to requests for medico-legal assessments, how to prepare reports, and how to prepare for attendance at trials, provided further impetus for research to support emerging needs in the medico-legal specialty. It was apparent that occupational therapists who sought sound information about “best practice” in the medico-legal specialty found only limited valid sources. Information tended to be difficult to obtain or anecdotal, while literature tended to be directed to medical practitioners or psychologists and their role in the courts.

Therefore, the researcher perceived that research into occupational therapy expert opinions on work capacity was needed to understand the current contribution of the profession and develop recommendations for maintaining and improving practice. It was anticipated that this information could be used to enhance the standing of practitioners and reduce the need for trial-and-error learning to develop competencies which could, potentially, jeopardise their reputation and that of the occupational therapy profession. For example, errors of judgement could potentially arise from a lack of understanding about differences in the relationship between the stakeholders in the medico-legal and rehabilitation contexts, or from not understanding the expert witness role.

Overall, the researcher concluded that there is a need for a systematic evaluation of occupational therapists’ provision of expert opinions on work capacity. A systematic evaluation would enable the profession to (a) more fully understand its contribution to medico-legal decisions about work capacity, (b) document the assessment and report
writing methods used, and (c) identify any training and development needs to improve practice.

Occupational therapists’ views in the literature further supported the researcher’s initial impressions of the need for research. Wyrick and Wyrick (1988) believed that recognition of the value of occupational therapists’ professional judgement as expert witnesses would enhance the reputation of occupational therapy. Morgan (1999) noted that there are few guidelines for occupational therapists in medico-legal private practice and that this may result in feelings of confusion and stress. Sterry (1998) stated that the quality of the work in this new specialty must be maintained through post-graduate training or the credibility of the profession will decrease.

1.8 The Significance of the Research

The importance of rigorously examining the contribution of occupational therapists to medico-legal decisions about work capacity can be linked to a recurrent theme in occupational therapy literature, namely, the need for theory to support practice. Several decades apart, Driver (1968) and Stanley and Cheek (2003) identified that theory development is needed to support the development of the occupational therapy profession. Based on the work of philosopher Auguste Comte, Driver (1968) observed three stages from knowledge to theory development in occupational therapy. First, there is the “mystical” stage in which older ideas are accepted, rather than questioned. Second, there is the “theoretical” stage where observations are made but are not examined with scientific rigour. In the third or “scientific” stage, knowledge needs to be subjected to critical scientific examination (Comte, as cited in Driver, 1968). The second stage may be likened to current understandings of work-related medico-legal
occupational therapy practice, and the research described in this thesis is indicative of
the third stage.

More recently, Stanley and Cheek (2003) emphasised the benefit of theory that
reflected the uniqueness and realities of occupational therapy practice and supported
the opportunities that could be offered by grounded theory methodology (B. Glaser &
Strauss, 1967; Strauss & Corbin, 1990). In relation to the present research topic, the use
of grounded theory methodology would enable the researcher to access the experiences
and perspectives of a number of medico-legal occupational therapists, and thus,
overcome the aforementioned difficulties of individual practitioners obtaining this
information. In addition, the experiences and perspectives of members of the legal and
medical professions who refer to occupational therapists and peruse their medico-legal
reports on work capacity could be obtained. A grounded theory of occupational
therapists’ contribution to medico-legal decisions about work capacity would be a
timely response to the increased demand for and interest of occupational therapists in
this developing medico-legal practice specialty.

1.9 Anticipated Benefits of Research into Occupational Therapy Expert
Opinions on Work Capacity

Research into occupational therapy expert opinions on work capacity is likely to
have a number of benefits including the following:

(a) the elucidation and documentation of occupational therapists’ contribution to
medico-legal decisions regarding work capacity;

(b) an analysis of the complex issues associated with occupational therapy practice
in this specialty from the viewpoint of relevant professionals;

(c) the synthesis of the data to develop guidelines to inform occupational therapy
professional reasoning and decision making; and
(d) the identification of the education and training needs of occupational therapists who provide expert opinions on work capacity, and strategies to address these needs.

It is anticipated that achieving each of these research outcomes for the occupational therapy profession will have broader socio-economic benefits for other stakeholders. Principally, injured workers can expect better informed practitioners who are more able to provide expert professional services for the settlement of their cases. Insurance companies responsible for paying for settlements decided by the courts would be better served by occupational therapists writing higher quality reports. Similarly, the judicial system would benefit from occupational therapists knowing how best to provide expert opinions on work capacity to assist the decision-making function of the courts. Ultimately, there is the potential for social and economic benefits arising from the research for the community that is concerned about a need for a balance between the rising costs of litigation and justice for its citizens with work-related injuries.

1.10 Organisation of the Thesis

The thesis is organised into four parts. Part A, “Introduction,” consists of two chapters. In Chapter 1, “Background of the Thesis,” the context, impetus and rationale for research into the occupational therapy contribution to medico-legal decisions about work capacity have been outlined. Chapter 2, “Perspectives from the Literature regarding Occupational Therapy Expert Opinions on Work Capacity,” will examine occupational therapy literature on the topic and supplement it with relevant legal, medical and allied health literature on expert opinions. The absence of research to inform occupational therapy practitioners, alluded to in Chapter 1, will be highlighted
by this literature review. Specific research aims and questions will be presented following a review of the literature in Chapter 2.

Part B, “The Research Design and Process,” will consist of two chapters. In the first of these, Chapter 3, “Methodology and Methods,” a rationale for the research methodology and methods will be provided. The selection of grounded theory to explore the interactions and processes encountered by occupational therapists providing expert opinions on work capacity will be explained. In Chapter 4, “The Participants,” the sample of participants with experience of occupational therapists’ contribution to medico-legal decisions on the residual work capacity of people with injuries will be described. The recruitment of participants and ethical considerations throughout the research will also be outlined in Chapter 4.

Part C will contain four chapters of results and discussions. These chapters will be based on textual data from interviews in which participants provided their perceptions and experiences of occupational therapists contributing work capacity in the medico-legal system. Chapter 5, “Understanding the Medico-legal System and Interactions with Stakeholders,” will provide the research participants’ experiences and perceptions of what an expert occupational therapist needs to understand regarding the contemporary medico-legal system in which they provide expert opinions. The roles of key stakeholders and their interactions with occupational therapists will be summarised. Chapter 6, “Identifying the Occupational Therapy Areas of Work Capacity Expertise that Assist the Courts,” will explore the participants’ views on the value, scope and nature of opinions that occupational therapists offer regarding work capacity, and issues related to standards of expert opinions. Chapter 7, “Assessing Work Capacity, and Forming and Reporting Opinions on Work Capacity” will examine the work capacity assessment and reporting methods occupational therapists use, and associated measurement and decision-making issues in forming
In Chapter 8, “Systematically Improving Occupational Therapy Expert Opinions on Work Capacity,” the trends impacting on occupational therapy expert opinions on work capacity, and strategies and principles to develop the medico-legal specialty will be addressed. This chapter will synthesise the participants’ proposals for improving standards of expert opinions on work capacity.

Part D, “Research Conclusions, Contributions and Implications” will begin with Chapter 9, “Identification of a Grounded Theory of Occupational Therapy Expertise in Work Capacity.” It will present a grounded theory derived from the data and verified by the participants. Chapter 10, “The Research Contributions and Implications,” will contain conclusions about the research, the research limitations, implications of the findings for occupational therapists, and recommendations for further research. In particular, the research findings will be related to previous literature and the significant contributions made by the research will be identified.

1.11 Summary and Conclusion

The emergence of occupational therapists who provide expert opinions on work capacity for the courts was traced to two sources. The first of these sources is established work rehabilitation practices and the second is the demand for medico-legal opinions on work capacity. The rationale and the significance of research on the contribution of the occupational therapy profession to this specialised area of practice and identification of ways to enhance the specialty were outlined. The way in which the thesis is organised into four parts containing ten chapters was presented.
PART A: INTRODUCTION

CHAPTER 2

PERSPECTIVES FROM THE LITERATURE REGARDING

OCCUPATIONAL THERAPY EXPERT OPINIONS ON WORK CAPACITY

2.0 Introduction

In the previous chapter it was identified that the occupational therapy profession includes a group of practitioners who provide expert opinions on work capacity in personal injury cases, and that there is a need to understand their contribution, map existing practices and find out how these can be further developed. In this chapter, the existing literature that informs practices in the evolving medico-legal specialty will be critiqued. Literature from three main perspectives will be integrated and presented in three sections. First, occupational therapy literature relating to medico-legal work capacity services will be comprehensively reviewed. Second, relevant literature on work-related assessment issues will supplement the medico-legal literature. Third, medico-legal literature on health professionals as expert witnesses will extend the occupational therapy perspectives. Finally, conclusions will be drawn about research that would extend current understandings of the topic.

In keeping with the procedure for literature reviews in qualitative research, literature was reviewed continually throughout the research (Patton, 2002). As the
central concept of expertise emerged in the data analysis, literature relevant to this concept was identified and reviewed.

The literature was searched systematically for relevant material, and, in some instances, when the literature was limited, the search extended back to 1980 (see Table 1). Various combinations of the following search terms and their variants were used when searching the literature: occupational therapy, work capacity, functional capacity evaluation, medico-legal, personal injury, common/case law, compensation, litigation, expert witness, and expert.

Table 1

Systematic Search Strategies

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<tr>
<td>1. Electronic searches of CINAHL, LexisNexis, Digital Dissertations and MEDLINE databases and electronic journals published from 1997 to 2005 were conducted using the search terms.</td>
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<tr>
<td>2. On-line search of The University of Queensland Library catalogues and off-line search of relevant journals, books, textbook chapters, and professional association newsletters.</td>
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<td>3. Search of reference lists of publications obtained from search strategies 1 and 2.</td>
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**Occupational Therapy Medico-Legal Work Capacity Services**

A review of medico-legal literature from occupational therapy sources revealed intermittent publications on medico-legal work capacity services dating from the 1980s. This occupational therapy literature emanated from Australia, Canada, the U.K. and the
U.S. Based on Galvan (1999), this body of literature is classified and presented as (a) theoretical perspectives, (b) research, (c) professional accounts of medico-legal services, or (d) professional and ethical guidelines.

2.1 Theoretical Perspectives Related to Medico-legal Opinions on Work Capacity

The theoretical literature from the U.K. and the U.S. applied a consultancy model to explain the increasing number of occupational therapists providing skilled and expert services to individuals and organisations outside the traditional therapist-consumer relationship (Craik & McKay, 2003; DeMaio-Feldman, 1987; Dudgeon & Greenberg, 1998; Reineke Lyth, 2000; Shriver, 1985). Congruent with this model, S. Strong (2002) described opinions based on FCEs as consultancies for insurers. Referral for occupational therapy medico-legal consultation may be categorised as consultee-led consultation in which “the relationships may be regarded as a purchase of expertise or second opinion, with the consultee having control over interventions with the clients” (Dudgeon & Greenberg, 1998, p. 802). Expertise refers to the quality or level of knowledge and skill of an expert as reflected in the expert's opinion (Oxford English Dictionary, 1989). According to Harris et al. (1994), Pratt (1996) and Shriver (1985), medico-legal services such as FCEs have been developed mainly by private sector organisations and private practitioners. Public organisations have also offered occupational therapy medico-legal services on a contractual or fee-for-service basis (Potts & Baptiste, 1989). Therefore, a consultancy model may be applicable to skilled and expert occupational therapists who accept referrals to provide medico-legal opinions on work capacity in Australia.

Some theoretical literature addressed ways to develop medico-legal expertise through tertiary education. Jacobs (1991a) reported that work practice litigation was a
component of a course on work assessment and programs, developed in 1986 at Boston University’s Department of Occupational Therapy. Jacobs proposed that a lawyer who specialised in work injury be part of the interdisciplinary team contracted to lecture undergraduate occupational therapists on work practices. Proposed topics included “providing expert witness testimony, the litigation process, giving a deposition, and the importance of documentation” (Jacobs, 1991a, p. 393). Similarly, Burwash’s (1999) tertiary education work program acquainted students with medico-legal documentation and incorporated advice from a legal professional about financial settlements. In addition, her occupational therapy work practices model demonstrated a comprehensive client-centred and occupation-focussed approach. The components of her model were (a) values clarification, (b) vocational exploration, (c) vocational choice, (d) job search, (e) starting work, (f) maintaining work, (g) returning to work, and (h) leaving work.

These undergraduate education programs indicate the potential areas for integrating components of medico-legal education for occupational therapists and the scope of occupational therapy work-related opinions. However, despite these recommendations the undergraduate and post-graduate education of occupational therapists on medico-legal work capacity opinions and the current education and training needs have not been examined in any known research.

As indicated in Chapter 1, “Background to the Thesis,” a number of occupational therapy conceptual models have been developed and applied broadly to occupational therapy practice. One of these models, the Model of Human Occupation (MOHO) (Kielhofner, 1995) has been applied to assessments of workers with injury (Moore-Corner, Kielhofner, & Olsen, 1998; Velozo, Kielhofner, & Fisher, 1998). The model has three occupational sub-systems, namely, performance system, habituation and volitional. These sub-systems have been used to explain the impact of chronic low back pain on the performance of work tasks such as squatting and climbing, disruption
to worker roles and habits including endurance, and changes in a person’s self
perception, values and motivation in relation to work (Abdel-Moty, Maguire, Kaplan,
& Johnson, 1996). It is unknown which, if any, of the occupational therapy conceptual
models is applied by occupational therapists to work capacity opinions.

Occupational therapists have contributed to interdisciplinary theoretical
perspectives related to medico-legal opinions on work capacity. In particular, they have
been concerned with the development of conceptual models of work disability and
health as relevant to government policy and the administration of work-related matters
(O’Halloran & Innes, 2005). The research of Matheson and colleagues (Gaudino,
Matheson, & Mael, 2001; Matheson, Gaudino, Mael, & Hesse, 2000; Matheson, Kane,
& Rodbard, 2001) has focused upon the “development, testing, validation, and
ultimately, implementation of an approach to disability determination based on
objective measures of function rather than medical diagnosis” (Matheson et al., 2001, p.
150). Matheson et al. (2000) questioned the validity of the 4th edition of the American
Medical Association (AMA) guides to the evaluation of permanent impairment for
work disability determinations, and proposed a six-stage Work Disability Model to aid
decision-making within the U.S. Social Security Administration through an increased
consideration of the impact of medical impairments on functional work abilities.

Classification and definition of concepts have been part of the occupational
therapy contribution to disability determination and associated research and
rehabilitation. In this regard, Gaudino et al. (2001) detailed the development of the
Functional Assessment Taxonomy (FAT), which is compatible with the Work
Disability Model and the related Units of Analysis Hierarchy. The FAT consists of 131
constructs categorised into 33 conceptual factors, organised into five domains of
function (Gaudino et al.), which are designed to facilitate objective assessment of work
disability. In a development that combines theoretical with practical considerations,
Innes and Straker (1998b) proposed a framework that conceptualises work-related assessments according to levels of function to be assessed. An adaptation of this framework was presented in O’Halloran and Innes (2005), in which 14 work-related assessments were related to individual performance and work levels. For example, in the Innes and Straker (1998b) framework, FCEs provide answers to questions about tasks, task elements and skills, while vocational assessments and work trials provide answers to questions about life roles and career. These theoretical developments serve to emphasise the conceptual complexity of work capacity assessments and, additionally, suggest that occupational therapy opinions regarding different aspects of functional work abilities may extend upon information regarding medical impairment in medico-legal decisions about work capacity.

Some other issues for the medico-legal specialty have emanated from discussions about occupational therapy conceptual models. Occupational therapy authors have identified compatibility between the interdisciplinary World Health Organisation (WHO) models (1980, 2001), and occupational therapy conceptual models of occupational performance (Law & Baum, 2001; Moyers, 1999). Attention has also been given to parallels between the International Classification of Functioning, Disability and Health (ICF) model (WHO, 1999, 2001), occupational therapy models and FCEs (Brintnell, 2002; Gibson & Strong, 2003; Holm, Rogers, & Stone, 2003; Sandqvist & Henriksson, 2004). Brintnell (2002) described an occupational therapy assessment service for the insurance industry and legal profession in Canada based on the Canadian Model of Occupational Performance (CAOT, 1997). The findings and recommendations were expressed in terms of ICF concepts to allow for ready identification of the claimants’ losses when compared to pre-injury functional status. Similarly, Gibson and Strong (2003) related FCEs conducted in a standard, safe environment (i.e., based in-doors) to assessments of activities and activity limitations,
and work trials or modified return-to-work programs to assessments of work participation or role performance in the rehabilitation context. Bernspång (1998) cited a number of studies that supported her contention that there is a weak relationship between discrete occupational performance components (e.g., range of movement) and occupational performance areas (e.g., ADL). She stated that remediating the former will not necessarily result in improvements in the latter. Sandqvist and Henriksson (2004) compared six conceptual frameworks used by occupational therapists including MOHO (Kielhofner, 1995) and ICF (WHO, 2001) and identified that occupational therapists focus on three dimensions of work functioning that interact with personal and environmental factors. The first dimension is work participation, which addresses societal level considerations such as worker role fulfilment, the labour market and legislation. The second dimension is work performance, which addresses individual level considerations such as worker skills and abilities. The third dimension is individual (physical and psychological) capacity, which addresses body structure and function such as muscle strength and memory.

The corollary is that individual capacity (i.e., impairment, performance components), work performance (i.e., work activities and task), and work participation (i.e., employability, competence in the worker role) are three conceptually different entities and need separate assessment and intervention strategies. Further, the conceptual distinctions indicate that there is a disparity between what FCEs measure and what they need to measure in the medico-legal system, that is, FCEs are not designed to measure work participation. Therefore it may be a challenge for occupational therapists in the medico-legal system to base opinions about the claimant’s future work participation solely on FCEs conducted in a standard, safe environment away from a worksite.
2.2 Research on Occupational Therapy Medico-legal Services

In research on medico-legal services, Hall-Lavoie (1997) examined the role of occupational therapists as expert witnesses in Alberta, Canada. Her research included data collected from mailed surveys returned by 62 occupational therapists and 141 personal injury lawyers who had utilised occupational therapy medico-legal services. In addition, 18 occupational therapists who provided medico-legal services were interviewed about their experiences as expert witnesses. Hall-Lavoie found that the occupational therapists provided a wide range of functional evaluation services including FCEs, homemaking evaluations, the cost of future care, and leisure assessments.

Although medico-legal work capacity opinions was not the sole focus of this research, Hall-Lavoie’s findings demonstrated that occupational therapy work-related services to solicitors included FCEs, workplace visits, vocational assessment, case consultation and critiquing of reports. In Alberta, lawyers rated occupational therapy medico-legal services overall as less important than those of medical and counselling professions, but ahead of other allied health professions. Hall-Lavoie’s study provided research findings about occupational therapists’ role as expert witnesses and their interactions with lawyers. Her research provides useful insights into marketing medico-legal services. However, the study has limited details regarding occupational therapists’ contribution to medico-legal decisions about work capacity, and the assessment and reporting methods used for that purpose. The section on recommendations for improving medico-legal expertise is brief and offers minimal guidance. The qualitative analysis of the semi-structured interview data lacks the rigour recommended for qualitative studies, such as participant checks of interview transcripts. In addition, the qualitative methodology is inadequately supported and described, and data were
analysed using a frequency count. This approach to qualitative data analysis is prone to oversimplification of findings and loss of subtle and complex meaning in the data.

A second relevant study directly addressed the use of FCEs by occupational therapists in the medico-legal system. Allen, Rainwater, Newbold, Deacon, and Slatter (2004) examined FCE reports of 14 occupational therapists with the aim of identifying the categories of information on which occupational therapists reported in personal injury cases. The authors examined 51 medico-legal FCE reports for clients, all of whom suffered with spinal pain attributed to a motor vehicle accident and for which they claimed compensation from the insurer. Content analysis of the FCE reports identified 6 categories and 34 sub-categories on which occupational therapists routinely reported objective and/or subjective information. The authors identified that occupational therapists assess a wide range of ADL, instrumental ADL, leisure, driving, pain and work-related activities to formulate opinions about the claimants’ current and future work capacities and job options. The scope of these occupational therapy work capacity opinions, as indicated by the percentage of occupational therapists who included each of the six categories in their reports, were: (a) physical capacities (61%); (b) classification of physical capacities according to one of five categories of physical exertion (i.e., sedentary to very heavy) (47%); (c) future intervention: rehabilitation (51%); (d) future intervention: work assessment (25%); (e) suitability for current job (84%); and (f) suitability for future job (71%). The 20 physical demands of work in the Dictionary of Occupational Titles (hereafter referred to as the DOT) (U.S. Department of Labor, Employment and Training Administration, 1991a, 1991b) were the basis of the majority of FCE reports studied, although most frequently only the critical physical demands of work were selected for targeted assessment in FCEs. Other patterns of assessment were evident, but were not fully explored in the study.
Allen et al. (2004) recommended that occupational therapists’ medico-legal reports state the extent to which they had relied on objective or subjective information in forming their opinions, and the credence given to each source when interpreting findings as a means of increasing the transparency and accuracy of medico-legal FCE opinions and recommendations. Despite identifying the typical content of occupational therapy medico-legal reports and providing general report writing guidelines, Allen et al. did not offer other strategies for developing medico-legal opinions. Furthermore, as Allen et al. did not interview the occupational therapy authors of the FCEs they were not able to offer any insights into the authors’ perceptions of their contribution to the insurer’s decisions or their rationale for selecting assessment tools or forming their opinions.

No other research that investigated occupational therapists’ role and methods specifically in relation to work capacity decisions in the medico-legal system was located. Thus, this suggested a significant gap in the literature and revealed an important opportunity for the present research.

2.3 Professional Accounts of Occupational Therapy Medico-legal Services

Professional accounts of occupational therapy medico-legal services constituted the largest proportion of occupational therapy publications on the research topic. They were infrequently and intermittently published over more than two decades. These accounts were based on personal experiences of the author/s and typically made limited reference to theoretical frameworks or research literature. However, in keeping with the aim of this research, they were written to provide guidance to occupational therapists in the evolving medico-legal specialty. In the professional accounts of these services a number of issues are typically addressed, often briefly.
The issues that relate to occupational therapists as expert witnesses on work capacity are addressed in this section under the following headings: (a) occupational therapy medico-legal role; (b) types of work-related opinions requested; (c) categories in work assessments reports; (d) FCEs; (e) professional reasoning to form opinions; (f) comparing occupational therapy opinions to other expert opinions; and (g) occupational therapists as expert witnesses, the expert witness role and/or medico-legal processes. Ethical issues identified in professional accounts are included in “Occupational Therapy Professional and Ethical Guidelines” (see section 2.4).

2.3.1 Occupational Therapists’ Role in the Medico-legal System

Professional accounts frequently refer to the occupational therapist’s role in the medico-legal system. Early literature on the topic described the role generically while encouraging occupational therapists to respond to opportunities in the emerging specialty through providing assessment and file review services to lawyers and agencies (Kornblau, 1988; Shriver, 1985). Commonly, assessments of independent living or work capacity were combined in reports. DeMaio-Feldman (1987) proposed that a fair and professional assessment of the impact of disability and injury on function was required. Amplifying the need for occupational therapists to develop their own role, Shriver’s (1985) observed that, constrained by the medical model, occupational therapists were not providing the stakeholders (identified as, medical practitioners, insurers, lawyers or injured workers) with the “clear, meaningful, and objective information” they needed “regarding the current and projected functional status of the injured client” (p. 29). More recently, Reineke Lyth (2000) reported that an emerging role for occupational therapists, when fraud is suspected, was to analyse the videotapes of insurers for consistency in performance of functional activities with claims and medical information. Hence, occupational therapists may adopt a number of medico-legal roles.
2.3.2 Types of Occupational Therapy Work-related Opinions Requested

L. Kennedy (1997a), DeMaio-Feldman (1987) and Morgan (1999) summarised occupational therapists’ opinions on work capacity as analysing and describing jobs and relating this information to past, present and potential jobs for the person with an injury. Shriver (1985) identified five questions about work capacity that occupational therapists could be asked to address in relation to their opinions. These questions related to the following: (a) the impact of the injury on work; (b) the need for vocational rehabilitation, including any return-to-work interventions; (c) whether the client was potentially using the disability for secondary gain; (d) the effect of pain on function; and (e) the client’s residual functional skills that can be transferred to other jobs. Although the identification of these questions was not based on systematic research, these questions may act as cues for occupational therapists preparing medico-legal work capacity opinions.

2.3.3 Categories in Occupational Therapy Medico-legal Work Capacity Reports

In addition to the types of opinions requested, Morgan (1999), L. Kennedy (1997a) and Potts and Baptiste (1989) identified their reporting categories in work capacity reports for claimants with injuries. Morgan (1999) provides the most comprehensive and recently published categories for medico-legal work capacity reports in the professional accounts. Specifically, her categories were: (a) medical history, including treatment and medication; (b) current status perceived by the client, including pain; (c) vocational information, including work history and capacities, and work goals and preferences; (d) avocational activities, including leisure; (e) professional observations of the occupational therapist; (f) assessed physical capacities,
including whole body and manual tasks for work; and (g) a comparison of the claimant’s work capacity with that required in current or proposed jobs, and with the physical demand categories for work in the DOT (U.S. Department of Labor, Employment and Training Administration, 1991a, 1991b).

Morgan (1999) also outlined her medico-legal cognitive assessments, although these appear to have an independent living and impairment focus, as work-related issues were not stated. She stated that these cognitive assessments complement but do not attempt to replace or duplicate neuropsychological testing.

There were several similarities between the assessment approaches of L. Kennedy (1997a), Morgan (1999) and the findings of Allen et al. (2004). In particular, there was a consistent use of the DOT’s (1991a, 1991b) five physical exertion demand categories as categories of universal work demands. Some small variations were noted. L. Kennedy noted the impact of the injury on the family, as her advice also applied to comprehensive assessments of function for clients with continuing care needs and for whom work capacity was not the principal focus of assessment. L. Kennedy recommended that, as required, job analysis conducted at the workplace, and simulated work may be undertaken. She also recommended additional areas of physical, cognitive and psychosocial function be assessed in the medico-legal system. These additional areas were: work aptitudes, strength, flexibility, motor skills, perception, activity tolerance, ability to remember and follow directions, work behaviours, and other factors specific to the individual. In addition, Potts and Baptiste (1989) included psychosocial information they recorded for people with chronic pain. These were the assessment of the pain experience, depression, self-esteem, lifestyle satisfaction, and self-monitoring of activity.

The professional accounts indicate that a range of work-related factors may be assessed in the medico-legal system. The DOT physical demands form the basic
category. In addition, assessments of psychosocial, cognitive, physical functioning, some work behaviours and job demands are included, as required. Other work-related assessment are a job analysis and simulated work tasks.

2.3.4 Functional Capacity Evaluations in Professional Accounts

In some of the professional accounts, occupational therapists reported whether they used standardised or non-standardised FCEs in the medico-legal system and outlined a range of assessment approaches and the rationale for their use. Shriver (1985) advised occupational therapists to use standardised norms as the basis of predictions about future vocational outcomes from which losses in terms of wages can be calculated, but she did not nominate suitable sources of vocational outcomes data for people with an injury. Morgan (1999) reported using “ERGOS,” a marketed standardised computer-based assessment, consisting of 60-90 minutes of clinical assessment with interview followed by 3 to 4 hours of physical capacity testing. However, L. Kennedy (1997a) cautioned that there was little evidence to support claims of manufacturers that high tech equipment and computer-generated reports were more reliable or valid than “simpler methods” (p. 4).

A number of professional accounts indicated that a combination of standardised and non-standardised assessments were used (Potts & Baptiste, 1989; L. Kennedy, 1997a; Shriver, 1985, 1989). While Potts and Baptiste (1989) and DeMaio-Feldman (1987) stated that reliable and valid assessments were preferred in the medico-legal system, as normative data increased the credibility of assessment results, they reported using a variety of non-standardised assessments including behavioural observations and clients’ self-report of pain and discomfort. For patients with chronic pain, Potts and Baptiste (1989) used a comprehensive range of assessments over an extended period of time. Their assessments and the time taken for each were as follows: (a) FCE (3 hours);
(b) a self-monitoring diary (2 to 4 weeks); (c) a home or job site visit (2 to 3 hours); and (d) a work placement (6 to 8 weeks).

The professional accounts only briefly attempted to justify or explain the choice of assessments in the medico-legal system. Consequently, following an examination of the remaining issues raised in the professional accounts, literature on FCEs that is predominantly written by occupational therapists will be examined in section 2.6. This will identify existing assessment practices for medical-legal occupational therapists providing work capacity opinions.

2.3.5 Forming Opinions: Advice from Professional Accounts

The occupational therapy professional accounts generally support forming an opinion based on the collection and comparison of information from two or more sources, including objective testing and skilled observation (L. Kennedy, 1997a; Shriver, 1989). Shriver (1989) proposed the use of multiple medico-legal assessment measures such as record review, interview, checklists, assessment of performance using standardised and non-standardised assessments, examination of the person, clinical observation and disability-specific treatment strategies and activities. Previously, Shriver (1985) had also recommended obtaining facts from several assessment sites (e.g., in-rooms, work and home). This use of triangulated assessment methods is consistent with current occupational therapy work assessment practices (Allen et al., 2004; Innes & Straker, 2002a; Pratt, 1997; S. Strong, 2002).

The comparison of objective information with subjective information from self-report is also commonly advised in the professional accounts. L. Kennedy (1997a) recommended that the occupational therapist “looks for consistency and compatibility between the diagnosis and reported activities and performance during the next phase of the assessment” (p. 3). Shriver (1985) stated that by comparing objective and subjective
information an assessor “could identify a potential malingerer or bring legitimacy to a client’s dysfunction” (p. 32). Similarly, Allen et al. (2004) regarded observation and measurement by occupational therapists as objective sources of information in FCEs, while claimants’ self-reports were regarded as subjective sources. Allen et al. encouraged occupational therapists to clearly identify whether sources were objective or subjective in their reports.

A review of current occupational therapy literature suggests that the issue of the plaintiff’s veracity is a common concern when there is potential for secondary gain (Baker, 1998; Edwards, 2000; Pohlman et al., 2001). Edwards (2000) estimated that “malingers” comprise 2-5% of all people reporting chronic pain and are characterised by demonstrating incongruity between the medical findings, their physical abilities and their complaints. Furthermore, she suggested that some malingerers exaggerated their pain in dramatic ways in order to receive “unwarranted financial remuneration” (p. 283). However, Shriver (1989) advised that occupational therapists may state an opinion as to whether the plaintiff’s symptoms are “real, imaginary or feigned” but must avoid commenting on the plaintiff directly, such as labelling him/her a malingerer (p. 257). L. Kennedy (1997b) not only noted the plaintiff’s sincerity of effort as a constant concern in the medico-legal system but also cautioned that neither physical testing alone nor “simplistic” calculations such as the “coefficients of variation of repetitive strength” methods were the solution (p. 2). Instead, a combination of assessments including the medical reports, history, self-report, functional testing, and workplace evaluation over a period of time were recommended. Support for this stance comes from physiotherapists Lechner, Bradbury, and Bradley (1998) who studied the reliability and validity of several methods of determining sincerity of effort, including coefficient of variation in muscle performance tests. However they concluded that the methods had been insufficiently studied and advised therapists against reporting
“symptom magnification” and “exaggerated pain behaviours” or the validity of results based on perceived levels of co-operation. Robinson and Danneker (2004) came to the same conclusion in a study of the use of muscle testing for the determination of sincerity of effort.

Recommendations to assist the person overcome the impact of injury form an essential part of occupational therapy medico-legal opinions. Common law personal injury litigation in the U.K. and Australia aims to return the person to the position they would have been in had the injury not occurred. L. Kennedy (1997a) and Shriver (1985) identified substantive areas of occupational therapy recommendations to support that aim. These areas were training, treatment of impairment, work hardening, modified or adapted work, ergonomic alterations, assistive devices, equipment or techniques. In spite of this aim, some guidelines suggest that occupational therapists’ recommendations for equipment should only include what is “reasonable and necessary” rather than the ideal (Occupational Therapy Australia - New South Wales, 1998, p. 17) or the most expensive and extravagant (Sterry, 1998).

The professional accounts are consistent with a wider body of literature by indicating that predicting the claimant’s future work outcomes (i.e., work participation or employability) with any certainty can be complex and difficult. Shriver (1989) advised that occupational therapists who are providing expert opinions need to understand differences between “possibility, probability and actuality” so as to advise the court if an outcome “might, could or would” follow from the findings (p. 257). This appears to be related to the need for civil law cases such as personal injury claims to establish facts “on the balance of probability,” where outcomes with less than 50% certainty are possible and those with greater than 50% certainty are probable (Schofield, 1999, p. 41). The medico-legal literature acknowledges the relative ease with which past economic loss is calculated and the relative difficulty of assessing
future economic loss. For example, Braithwaite (1997) identified that it can be difficult to calculate a career path if a person was not employed at the time of the injury, or there was an anticipated promotion. He said that insurance companies will argue that more positive outcomes would not have been achieved.

The literature indicates that forming an expert opinion depends on integrating a number of sources and types of information. Shriver (1989) concluded, “An [expert] opinion is no stronger than the facts that support it and the explanation of its basis” (p. 254). The value of an expert’s opinion depends on comprehensive factual information, her/his perceived credibility and conclusions that are both reasonable and persuasive. Yet, differing professional or clinical reasoning processes such as scientific and narrative reasoning may be used by occupational therapists (Chapparo & Ranka, 2000; Mattingly & Fleming, 1994). Allen et al. (2004) proposed that these mental processes may result in variations in the information collected during work capacity assessments and influence conclusions about the person’s employability and rehabilitation needs presented in their FCE reports. In the clinical setting, Fleming (1994) found that occupational therapists used conditional reasoning processes to holistically envision the client’s present and predict future occupational performance or function of their clients. Higgs, Jones and Refshuage (1999) also emphasised that during conditional (which they alternatively titled “predictive”) reasoning the allied health therapist estimates outcomes based on interview, assessment, the clients’ responses to treatment and the management of the condition. Although conditional or predictive reasoning (hereafter referred to as predictive reasoning) appears to have direct application to expert opinions on work capacity, no independent examination of professional reasoning and decision-making processes applied in the medico-legal system could be found. Research is needed to further elucidate the sources and types of information occupational therapists
use to form opinions and how they interpret findings in the medico-legal system, thereby extending the information in the individual professional accounts.

2.3.6 Comparing the Occupational Therapy Role to that of Other Experts

In the professional accounts L. Kennedy (1997b) and Shriver (1985) compared the role of medico-legal occupational therapists with that of other experts including medical practitioners, vocational evaluators or counsellors, psychologists and physiotherapists. Both authors indicated the advantages of stakeholders consulting with occupational therapists. L. Kennedy noted that medical practitioners are often relied upon to make decisions about a person’s ability to work, but that this credibility afforded them may be misplaced if they are not trained in job analysis and base their opinions of function on brief medical tests and office visits. L. Kennedy supported the views of the Canadian Medical Journal (1997, p. 680) which encouraged physicians to assist their clients to return to work by referring more complex patients for comprehensive and objective assessments of functional capacities and limitations in relation to job demands.

L. Kennedy (1997b) and Shriver (1985) had found that vocational evaluators or counsellors have difficulty assessing the person’s suitability for work based solely on pencil and paper tests without assessments of their physical capacity and psychosocial barriers to work. L. Kennedy noted how the psychologist’s assessment of cognitive impairment and mood needed to be complemented by “real world” observation and trial of strategies. Similarly, the physiotherapist’s concentration on physical modalities and impairment could be difficult for the court to translate into the impact on the person’s capacity to perform functional tasks and their complex life roles. In a final consideration, L. Kennedy compared treating rehabilitation occupational therapists with independent medico-legal occupational therapists and stated that the former tend to
maximise assets and minimise impairments in their reports “in keeping with a rehabilitation philosophy,” whereas, in the medico-legal system, both assets and limitations must receive equal attention (p. 5). Wyrick and Wyrick (1988) concurred that, unlike rehabilitation assessors, occupational therapy medico-legal assessors must state what the person is unable to do.

While these professional accounts provide an interesting and valuable source of information and “best practice” they appear to be based wholly or partly on the knowledge and experience of individual authors. Individual professional accounts lack the rigour needed for research evidence, and there are limits to the extent they can be generalised. The extent to which these individual professional perspectives on medico-legal practices differ between occupational therapists and other relevant stakeholders needs to be systematically investigated.

2.3.7 Occupational Therapists as Expert Witnesses on Work Capacity

Some occupational therapy authors provided guidance to their peers called as expert witnesses. Shriver (1989) presented the earliest detailed guidance found in the work-practices literature. She drew on the legal literature to explain to occupational therapists how the court qualifies experts and how to conduct themselves in court. Shriver (1989) also suggested ways of dealing with “various tricks and confusing questions” posed by barristers in cross-examination (p. 268). For these situations, Ekelman Ranke (1997) described nine courtroom strategies for occupational therapists. Potts and Baptiste (1989) and Shriver (1989) offered some limited advice about managing emotions, especially feelings of stress in the courtroom. The extent to which these same issues and strategies apply in medico-legal systems outside the U.S. is not known.

In Australia, Morgan (1999) identified those aspects of work capacity on which she was examined in court. Specifically, she was asked (a) the hours the person could
work, (b) the duties they could perform, and (c) his/her pace and productivity. Through
examination and cross-examination she was asked to compare the assessed work
capacity to the person’s pre-injury duties, alternative work with or without
rehabilitation or training, and the person’s future vocational potential including
suitable alternative jobs. Morgan reported being asked about the validity of the
assessment methods used. In an attempt to determine the person’s sincerity of effort,
barristers asked her opinion as to whether the person had performed with optimal
effort. Morgan’s experience suggests that occupational therapists would benefit from
having guidelines to address commonly asked questions in personal injury cases.

2.4 Occupational Therapy Professional and Ethical Guidelines

Professional and ethical guidelines for occupational therapists aim to set
standards of practice by reference to an authoritative source. Two such examples were
evident in the literature. They are: (a) the guidelines developed by Occupational
Therapy Australia - New South Wales (1998), on behalf of the national association of
occupational therapists; and (b) those discussed by Sterry (1998), who interpreted the
British Occupational Therapy Code of Practice in relation to medico-legal
consultancies. As alluded to in section 2.3, ethical issues were also raised in the
professional accounts of DeMaio-Feldman (1987), Morgan (1999), Wyrick and
Wyrick (1988).

Occupational Therapy Australia - New South Wales (1998) has developed the
most recent and comprehensive guidelines for use by Australian occupational
therapists undertaking medico-legal assessments and reports. These professional
guidelines outline the medico-legal processes from the acceptance of referrals to
presenting evidence in court. The guidelines indicate that knowledge of pertinent
legislation will assist in meeting various reporting requirements. The guidelines note
that assessment methods may include the claimant’s self-report of history, occupational therapist’s observation of tasks with stated duration of observation and level of claimant performance, and standardised assessments. While some experienced medico-legal occupational therapists avoid standardised assessments preferring to use “what they have seen and measured functionally” (Occupational Therapy Australia - New South Wales, 1998, p. 12), the authors predicted that standardised assessments may be requested more frequently in the future. The authors stated that reports should have conclusions or opinions that are specific and unambiguous. The authors acknowledged that the prospect of being an expert witness may be “quite daunting’ or “frightening,” and that “brave” therapists “conquer fear” and “overcome pride” to request professional supervision (Occupational Therapy Australia - New South Wales, 1998, p. 29).

These guidelines are generally consistent with the professional accounts, but are additionally endorsed by the professional association and based on the combined “wisdom and experience” of 13 occupational therapists who provided medico-legal services within the state (Occupational Therapy Australia - New South Wales, p. 4). Furthermore, the guidelines include useful practical information that is organised according to the medico-legal process and expressed simply and clearly. In spite of these benefits, the document has four main limitations for occupational therapists providing expert opinions on work capacity. First, the methodology used to arrive at the findings is not documented in detail, leaving uncertainty about whether a rigorous research process was used. Second, the guidelines do not attempt to address specialty practice issues such as assessment methods in any detail. Third, the focus is on holistic assessments of function for adults and children, especially assessment of their future care needs, so separate assessments of “vocational capacity” (p. 5), “educational and/or work potential” or “work capacity” (p. 16) for adults are not fully explained or
addressed. Fourth, ways of enhancing medico-legal opinions are not within the scope of the guidelines.

Sterry (1998) related the U.K. Code of Ethics for occupational therapists to medico-legal practices and added a number of additional points to those made in the Occupational Therapy Australia - New South Wales (1998) guidelines. She gave particular emphasis to humane treatment of the person being assessed. For example, the claimants’ wishes should be respected where possible, and assessments should not cause them undue pain or fatigue. Ethical relationships with the legal practitioners were highlighted including the need for occupational therapists to be honest about realistic completion times for reports. Sterry stated the need for professional integrity, which includes being prepared to change an opinion in the event of changed circumstances or a reasonable case being made by another expert.

The occupational therapy medico-legal literature typically emphasised ethical professional practice to maintain integrity in the role of an expert witness (Morgan, 1999; Occupational Therapy Australia - New South Wales, 1998; Sterry, 1998). A recurrent theme was the need for occupational therapy opinions to be independent, objective and free of bias. Sterry (1998) was explicit that occupational therapists should avoid the role of advocate for the plaintiff while Occupational Therapy Australia - New South Wales (1998) advised occupational therapists to market their services to both plaintiff and defendant solicitors to avoid perceptions of bias. Wyrick and Wyrick (1988) stated that it was the ethical and moral responsibility of occupational therapists to give accurate and valid information, reminding them that this could be tested under oath during cross-examination.

Morgan (1999) appears to be unique in the occupational therapy literature in providing personal insights into the professional and ethical challenges she has encountered in undertaking medico-legal assessments. Ethical challenges that Morgan
(1999) identified included (a) arranging payment while maintaining professional independence, (b) being asked to withhold reports or sections of the report unfavourable to the claimant’s case, (c) being asked to provide information “off the record” for the opposing side, (d) being asked to comment on function without seeing the claimant and on the basis of another occupational therapist’s report, and (e) being offered gifts by a client.

2.5  Summary and Conclusion: Occupational Therapy Medico-legal Literature

In summary, the occupational therapy medico-legal literature provides some useful insights into occupational therapists as medico-legal experts on work capacity. In the limited theoretical literature a consultancy model has been applied to occupational therapy medico-legal expertise, and two educational programs demonstrate input of the legal profession to relevant undergraduate education. Professional accounts represent the majority of the literature, although the quality, quantity and recency of information in some professional accounts limit their value and application. Although some medico-legal professional and ethical standards exist, they lack detailed guidelines for occupational therapists on work capacity assessment and reporting. Only two examples of research directly relevant to the current research were located (i.e., Allen et al., 2004; Hall-Lavoie, 1997). Thus, the literature lacks comprehensive research into the contribution of occupational therapy to medico-legal decisions about work capacity and the means by which experts make that contribution. Attention will now be given to occupational therapy literature that addresses work-related assessments. This literature relates predominantly to the rehabilitation system and less directly to the medico-legal system. That is, work-related assessments in the medico-legal system are not fully understood.
2.6 Potential Challenges for Experts Using Work-related Assessments

There are several potential challenges for experts using work-related assessment in the medico-legal context. Mueller, Adams, and Isaac (1997) and Gibson, Allen, and Strong (2002) identified that some recurrent issues in the medico-legal literature were the ways in which litigation or compensation can influence return-to-work outcomes, maximum voluntary effort and manifestations of abnormal illness behaviour. From a different perspective, Shaw (2000) noted the potential for external agencies such as insurers and litigious institutions in Canada to influence work-assessment practices. Examples include limiting FCE reports to one page and/or capping reimbursements.

Examination of the relevant occupational therapy literature on work-related assessments revealed the preponderance of attention given to FCEs, while recognising that the FCE is not a single entity. V. J. Rice and Luster (2002) stated that although a range of assessments is available for assessing work performance, the majority of these can be classified as FCEs. FCEs are an essential service provided by occupational therapists internationally (Deen et al., 2002; Jang, Hwang, & Li, 1997; Jundt & King, 1999; Lo, 2000; Pohlman et al., 2001; S. Strong, 2002). Rehabilitation providers, employers and insurers rely on the results of FCEs to make important decisions regarding rehabilitation provision and return-to-work readiness of injured workers. Of relevance to the medico-legal system, Pratt (1997) identified that FCEs can be used to make decisions about compensation and benefits claims, explore alternative careers, and recommend workplace and workstation modifications. Yet, according to V. J. Rice and Luster (2000), more than 55 FCEs are available, and Matheson (2001) identified that there are more than 800 work-related assessments available to occupational therapists that rely on performance-based testing, observation or self-report and that
include a vocational assessment. This literature indicates that the large choice of assessments may pose difficulties for occupational therapy assessors in the medico-legal system.

2.6.1 Scope of FCEs Conducted by Occupational Therapists

The scope of FCEs can vary, although the majority of occupational therapy authors concur that the functional physical capacities are the primary focus. Some definitions emphasise that FCEs can either evaluate the person’s performance of physical demands for work generally or for specific jobs (Gibson et al., 2002; Innes & Straker, 1999b, 2002b; V. J. Rice & Luster, 2001). King, Tuckwell, and Barrett (1998) stated that one goal of FCEs is to measure a person’s functional physical abilities to perform work safely, adding a further consideration to the scope of FCEs.

Several authors considered that occupational therapists should assess cognitive and psychosocial components of work performance in conjunction with the assessment of the injured person’s physical capacity for work (Braveman; 1999; Jang et al., 1997; Joss, 2002; Keogh & Fisher, 2001; Lo, 2000; Pratt, 1997; V. J. Rice & Luster, 2002). V. J. Rice and Luster (2002) stated that a FCE was “a systematic process designed to assess functional abilities. Functional abilities may include all physical and psychosocial abilities required in a work setting, such as physical, cognitive, emotional, and communication abilities” (p. 716). More specifically, Pratt (1997) included assessments of workers’ skills, endurance and behaviours such as coping, stress, and pain.

Psychosocial skills and psychological components have been recognised as part of occupational therapists’ core practices and essential to holistic understanding of function (AOTA, 1994, 1997; Arnold & Devereaux, 1997; V. J. Rice & Luster, 2002; J. Strong, 1996). Work-related psychosocial factors from the Uniform Terminology for
Occupational Therapists (AOTA, 1994) include values, interests and coping skills. The Uniform Terminology provides a classification system for areas of performance assessed by occupational therapists. V. J. Rice and Luster (2002) stated that occupational therapists recognise that successful work performance depends on physical and/or psychosocial factors. Further they claimed that occupational therapists made a unique contribution to return-to-work programs based on their “solid background in the full spectrum of human performance (physiological, biomechanical, psychosocial, and behavioural)” (p. 719). Gibson and Strong (1998) supported the integration of psychosocial factors such as pain intensity, pain location, pain behaviour, self-efficacy and fear of re-injury into FCEs for people with chronic pain. Gibson, Strong, and Wallace (2005) provided initial evidence for combining psychosocial and physical assessments in the GAPP FCE, a standardised approach to evaluating the performance of clients with chronic back pain.

In addition, a number of occupational therapists have promoted the inclusion of psychosocial factors in assessments or programs to increase work participation for workers with injuries (Allen & Carlson, 2003; Gibson et al., 2002; Moore-Corner et al., 1998; Pratt, 1997; Velozo et al., 1998). For clients with traumatic brain injury (TBI) in particular, occupational therapists assess a number of cognitive components of work-related performance together with behavioural or psychosocial components (Bootes & Chapparo, 2002; Radomski, 2001). Cognitive components impacting on work performance may include sequencing of work tasks, and problem solving at work, while psychosocial components may include initiative, self-concept and self-control. Thus, the inclusion of psychosocial and cognitive components of work performance is well supported within the occupational therapy literature on work-related assessments.

Understandably, those FCEs designed and developed by physiotherapists, who are experts in musculoskeletal injuries and which are based on biomechanical and
physiological models rather than a psychophysical model, are less likely to include psychosocial and cognitive factors as a basis for decision-making in the medico-legal or rehabilitation systems. However, in the rehabilitation context, Kielhofner et al. (1999) criticised those assessments of workers that focus only on physical capacity, while ignoring personal and interpersonal factors. Innes and Straker (1998a) found that many work-related assessments lack psychosocial and cognitive components of assessment. The extent to which these considerations influence the scope of FCEs in the medico-legal system is not known, but information about current practices and influences would assist occupational therapists to make well-informed choices.

2.6.2 Standardised and Non-standardised FCEs

FCEs are a group of standardised and non-standardised measures (Gibson et al., 2002; Pratt, 1997). However, the majority of rehabilitation literature by occupational therapists appears to favour the use of marketed standardised FCEs. In a study of occupational therapy work rehabilitation practices in the U.S., Jundt and King (1997) ascertained that as many as half of the rehabilitation providers who employed a majority of occupational therapists used at least one marketed FCE system. In their survey, Jundt and King (1997) found that Isernhagen Work System, ERGOS and Key Method systems were commonly purchased systems. The popularity of Valpar Component Work Samples was noted by occupational therapists in Hong Kong (Lo, 2000). In Australia, Workhab, Valpar and West systems appear to be commonly used (Deen et al., 2002). In Scotland, Jackson, Harkness, and Ellis (2004) reported on the use of Valpar and the Worker Role Interview, and the resultant improvements to occupational therapists’ reports on their patients’ work abilities. However, a number of factors may complicate the use of standardised marketed FCEs when assessing a person’s work capacity in the medico-legal system.
Whereas much of the literature on FCEs in the rehabilitation system has focused on the need for reliability and validity of standardised FCEs, some literature has critically appraised FCEs to provide some cautionary advice for users. Existing standardised FCEs do not have high levels of established reliability or validity for measuring work participation (Innes & Straker, 1998b, 1999a, 1999b, 2000; King et al., 1998; S. Strong, 2002). Innes and Straker (2000) identified that some of the ten standardised marketed FCEs they evaluated had good reliability for measures of tasks and skills, but lacked validity required for work performance and work participation.

A principal concern in the medico-legal system is the low established levels of predictive validity for FCEs. The predictive validity of measures of work capacity or residual functional capacity is an inherent design problem (Innes & Straker, 1999a, 1999b; King et al., 1998) and has only recently been the subject of research (Fishbain et al., 1999). Lack of sound predictive validity could present a problem for occupational therapy assessors in the medico-legal system where accurate prediction of a person’s future work capacity is an important reason for referral. These deficiencies in marketed standardised FCE may limit the extent to which occupational therapists can extrapolate from their findings and form opinions.

Another concern about the use of standardised FCEs is their low contextual validity (S. Strong, 2002; Velozo, 1993). Occupational therapists have queried the extent to which information gained in a static environment can reflect performance in a dynamic work environment. Complementary approaches have been recommended to increase contextual validity. First, simulated work tasks, work trials and work-site assessments have been proposed as ways of increasing the contextual validity of FCEs (S. Strong, 2002). Second, V. J. Rice and Luster (2002) proposed that valid FCEs include work tasks identified in a job analysis. In their review of predictive validity in 21 research studies of work performance in the rehabilitation system, they found that
the most successful predictions had several consistencies, accounting for 60% of the variance. A detailed job analysis was used consistently and incorporated multiple assessment techniques, which included: (a) interviews with rating of key tasks for frequency, duration, and difficulty; (b) direct observation; (c) videotaping; (d) measurements of masses moved and forces exerted; and (e) identification of pace and frequency. V. J. Rice and Luster (2002) concluded, “The fidelity of the evaluation tool depends on the use of the multiple constructs identified during the job analysis and accurately translating the description into the development of the FCE” (p. 722). It is uncertain how these findings are applied in the medico-legal system, especially if a detailed job analysis can not be obtained (e.g., when the person is unemployed or access to the workplace is restricted by employers).

Despite the limitations of standardized assessments, non-standardized FCEs may be perceived as less credible in the medico-legal system (King et al., 1998). King et al. noted that the increased use of FCEs in the medico-legal system meant that test standardisation was increasingly scrutinised along with the qualification of the user.

More recently, Innes and Straker (2002b, 2003) and Pohlman et al. (2001) raised doubts about the extent to which occupational therapists use standardised assessments in the medico-legal system. A study of the FCE practices of Australian occupational therapists and physiotherapists conducted by Innes and Straker (2002b) found that therapists may choose to use both qualitative (i.e., non-standardised assessments) and quantitative (i.e., standardised) approaches, and that qualitative approaches were predominantly used in workplace assessments. In the U.S., Pohlman et al. (2001) examined the ways that occupational therapy work programs could best meet workers’ compensation insurers’ needs. As a group of assessments, FCEs were rated as either very or extremely useful by all respondents, but no surveyed insurer chose a provider based on their use of a standardised assessment and all were satisfied
with the current assessment procedures. Both these studies suggest that both standardised and non-standardised approaches may be used in some medico-legal systems, and that a number of factors other than the FCEs used contribute to insurer’s selection of occupational therapy services. However, the attitudes of occupational therapists and other stakeholders in the medico-legal system to standardised and non-standardised FCEs have not been documented in Australia.

Some authors have perceived that there is a trade-off between measures that are reliable and those that are valid (Dick, 1999; Field, 1990). Field (1990) highlighted the difficulties in achieving both a reliable and valid assessment of work task competencies in the trades. Assessors often have a choice between reliability and validity, because as an assessment becomes more realistic it may become less reliable. If it becomes “rigidly structured” it becomes less representative of the actual work tasks (Field, 1990, p. 206). As a solution, Field proposed that both measurement attributes be used in different stages of the assessment or that simulated work stations are used (e.g., mock-up of bank teller work station, parallel operator consoles in power stations or mines). It is unknown if the application of these assessment principles to work performance of trades’ people without injury reflects medico-legal occupational therapists’ assessment of work performance in a wider range of jobs for people with injury.

Occupational therapists may use a range of assessment approaches in their practice (Fawcett, 2002; Hinojosa & Kramer, 1998; Ottenbacher & Christiansen, 1997). Categories of assessments include the following: norm-referenced and criterion referenced, standardised (quantitative) and non-standardised (qualitative) assessments, and performance-based observation versus self-assessments (see Appendix A, “Glossary of Medico-legal and Professional Terms” for definitions of these terms).

Dunn (2001) noted that when standardised measurement is either considered inappropriate or is unavailable qualitative measurement strategies such as interviews,
skilled observation and document analysis must be used with validity issues in mind. Similarly, Corcoran (2001) proposed that qualitative measures are best suited to areas that are not well-defined and are difficult to measure. The extent to which these measurement principles are applied to the medico-legal system explicitly has not been explored in the literature.

In some literature, there is an increased focus on understanding the contribution of occupational therapists to medico-legal assessments. King et al. (1998) noted that the background (e.g., qualifications) of the therapist was of particular importance when she/he served as an expert witness. Reflecting on the difficulties of using FCEs in their present state of development, S. Strong (2002) identified that opinions derived from them also depend on the assessor’s “unique attributes as a clinician and a person” (p. 1). She said that developing expert practice needed self-reflection, continuing professional education and inclusion of evidence-based practice (EBP) principles. More specifically, S. Strong (2002) recommended that “exposure to a range of workplaces and occupations, additional education concerning measurement principles and techniques, and fine tuning of report writing and other communication skills” were required (p. 4). She identified that mentors, academic programs and professional associations are sources of continuing development. Consequently, King et al. (1998) and S. Strong (2002) have suggested that personal factors may be important when experts assess work capacity.

2.6.3 The DOT System

The DOT system of the U.S. Department of Labor, Employment and Training Administration (1991a, 1999b) has been adopted extensively as the basis of measuring physical activities for work and comparing the match between the worker’s capacity and the physical demands of the job (Gibson et al., 2005; King et al., 1998; Mueller et
al., 1997; Pratt, 1997). These assessments focus primarily on the 20 physical demands listed by the DOT (1991a, 1991b) in which the physical demands of jobs were further rated by intensity and frequency of lifting to allow them to be further classified. These classifications are sedentary, light, medium, heavy and very heavy work (see Appendix K for a sample FCE format based on the DOT with a guide for classifying the worker’s work capacity).

**Health Professionals as Expert Witnesses**

### 2.7 Medico-legal Literature for Health Professionals

In Chapter 1, “Background to the Thesis,” several aspects of the medico-legal system relating to occupational therapy involvement in personal injury cases were identified. The body of literature presented here examines additional aspects of the medico-legal system relevant to the research topic.

There is ample literature available on expert witnesses and legal evidence. However, much of this body of literature applies to jurisdictions outside the scope of this thesis. For example, Freckelton and Selby’s (2002) landmark text on experts and their evidence applies to both criminal and civil cases and the Federal Court of Australia. A discerning occupational therapist needs to separate out information that applies to civil law cases. Furthermore, this literature is written for experts in civil law cases and needs to be examined for its application to personal injury cases. For example, civil law cases relating to child custody are likely to have limited relevance to personal injury cases. Occupational therapists need to take a further step and examine the literature that applies to medical and health professionals who provide expert opinions in personal injury cases. A final step for occupational therapists is to glean
useful information from literature that is directed to other health professionals, namely, medical practitioners, psychologists, physiotherapists and social workers.

Similar to the body of literature on occupational therapy medico-legal services, the body of literature on health professionals as expert witnesses includes a range of literature types (i.e., theoretical, professional accounts, research, professional and ethical guidelines) written by lawyers and health professionals with experience as expert witnesses. This body of literature will now be examined for its application to the present research topic in sections on (a) the increased use of health professionals as expert witnesses, (b) trends impacting on expert witnesses, (c) experts and evidence, (d) evidence and expertise, and (e) expert witnesses and plaintiffs/claimants.

2.8 The Increased Use of Health Professionals as Expert Witnesses

Medical practitioners and other health professionals are frequently requested to provide reports in personal injury litigation (Ward & Braithwaite, 1997). Historically, the legal profession has obtained expert opinions on impairment and disability from specialised and independent medical practitioners, but in recent decades the scope of expertise needed by the courts has increased. The increased use of expert witnesses by the courts has been attributed to the increased volume and complexity of cases, the emergence of sub-specialities of science, engineering and medicine, and to the development of sub-specialities in the law (Gore, 1992). The increased demand for occupational therapy expert witnesses can be linked to this trend.

2.8.1 Medical Specialists as Expert Witnesses

Professional accounts in the medical literature (a) delineate the formal roles of stakeholders and medical specialities, (b) advise on formats for expert assessments and reports, and (c) discuss expert medical opinions. Particular attention has been given to
preparation of medical expert witnesses (Breen et al., 1997; Dix, Errington, Nicholson, & Powe, 1996; D. Tait, 1999; Ward & Braithwaite, 1997). It is frequently stated that experts and their reports need to be honest, impartial and objective (Breen et al., 1997; D. Tait, 1999).

A number of relevant professional bodies and representatives of medical specialties have developed medico-legal assessment guidelines and codes of ethics for medical practitioners (e.g., Allnutt & Chaplow, 2000; Australian Medical Association, 1997; Medical Board of Queensland, 2000; Royal Australian and New Zealand College of Psychiatrists, 1998). The Australian Medical Association guidelines made a number of references to terminology, the role of the medical expert, reports, attendance at court and costs. Although many aspects of these professional guidelines and codes of ethics for medical practitioners are not directly applicable to occupational therapists, they extend the information available to occupational therapists about the medico-legal system, especially a comparison of expected standards of professional conduct.

Medical practitioners have been particularly concerned with the valid measurement and reporting of impairment (e.g., Andersson, 1998). The AMA guides to permanent impairment (Cocchiarella & Andersson, 2001) have been progressively refined for this purpose, and are used to increase inter-rater reliability by having medical practitioners access the same standards (Butler & Park, 2000). However, the use of AMA guides have been criticised for not achieving this goal (Dembe, 2000). One reason given is that the ratings in the AMA guides are not based on scientific and medical evidence (Dembe, 2000). A second reason given is that impairment ratings concern loss of body structure and function and these have been incorrectly applied to disability, a concept incorporating the ability to meet personal, social or occupational demands and to meet legislative requirements (Dembe, 2000).
A number of studies have found that medically assessed impairment ratings are inadequate predictors of function, work capacity and/or wage loss (Butler & Park, 2000; Cornes, 1997; Cornes & Aitken, 1992; Reville, Neuhauser, Bhattacharya, & Martin, 2002). Notably, Donelson, Aprill, Medcalf, and Grant (1997) found that in low back pain, radiographic evidence alone did not accurately identify loss of function. One difficulty is that impairment represents a stage on a continuum from impairment or loss of structure and function at the beginning of the injury to “loss of earnings as the final outcome of the disability process” (Butler & Park, 2000, p. 155). Butler and Park found that impairment ratings accounted for less than 3% of the variation in lost wages in a study of 810 assessments after controlling for pre-injury wages, and recommended that “hybrid” approaches that include individual demographics and job circumstances were required. Similarly, Reville et al. (2002) found that there was no objective scientific basis for ranking different upper limb impairments using the California Permanent Disability schedule. In particular, shoulder injuries were inequitably compensated using percentage impairment as an indicator of disability using that impairment rating. Consequently, there is some support in the literature for medical referral to other professions that distinguish between measures of impairment and functional outcomes such as employment (Cornes & Aitken, 1992; WHO, 2001).

There are some discrepancies in the literature about the focus of medical opinions in personal injury cases. Some medical literature indicated that medical practitioners mainly provide opinions on claimants’ impairments while other literature included opinions regarding the implications of injuries for employability (Andersson, 1998; Ellis, 2001). According to Ellis (2001), medical practitioners provide opinions on the work-relatedness of plaintiffs’ health conditions and make assessments of employability at the request of an employer, insurer or the claimants’ lawyers. Bridge and Twible (1997) distinguished between the biomedical prognosis given by medical
practitioners in which environmental contexts are rarely considered, and occupational therapists’ predictions of the potential functional outcomes of health conditions in which environmental contexts are always considered.

Some authors have recognised that, unlike impairment, measurement of function and disability is difficult, and findings are difficult to quantify (Andersson, 1998). Consistent with Butler and Park’s (2000) proposal for overcoming the limitations of impairment ratings, some authors consider additional functional information should be incorporated into disability evaluations. The additional information may include: (a) narrative thresholds (i.e., explanations of the impact of an injury on a person against certain criteria) (Arup, 1998); (b) contextual information (Matheson, Gaudino, Mael, & Hesse, 2000; Molloy, Blyth, & Nicholas, 1999); and (c) psychosocial factors (Molloy et al., 1999). Occupational therapists are trained to provide this functional information, but the extent to which it is requested of them in the medico-legal system is uncertain. Medical specialists’ views on the assessment roles and practices of occupational therapists and medical specialists in the medico-legal system would assist in clarifying the contribution of occupational therapists to personal injury cases.

2.8.2 Psychology Professionals as Expert Witnesses

Apart from medical practitioners, a number of other health and rehabilitation professionals have a body of literature to guide them in the medico-legal system. For example, neuropsychologists, psychologists and other mental health professionals can refer to comprehensive professional guidelines relating to the expert witness role (Gudjonsson & Haward, 1998), medico-legal assessment and report writing (Blau, 1998), and rigorous cross-examination (Brodsky, 1991; Stern, 1995). Some literature for psychologists applies to both civil and criminal cases. Civil cases may include a
range of situations apart from personal injury litigation (e.g., child protection). While some of this literature has limited applicability to occupational therapy, authors such as Brodsky addressed some more complex questions and situations that experts may encounter and which have application to occupational therapists who provide medico-legal work capacity reports and appear as expert witnesses. For example, experts on work capacity may be challenged to state “the theoretical and scientific foundations of work abilities” that would lead to a professional opinion (Brodsky, 1991, p. 46). In one instance Blau (1998) suggested that personal injury litigation is also known as the “battle of the experts” because experts evaluate and perceive the effects of injuries and future outcomes differently (p. 215). In a recurring theme in the medico-legal literature, Blau noted that professional experts might be perceived as biased towards the retaining plaintiff or defendant lawyers, but that it is the expert’s role to be scrupulous in avoiding any bias.

2.8.3 Research on Medical Specialists and Psychologists as Experts

Although the preceding bodies of literature about the roles of medical practitioners and psychologists in the medico-legal sphere are predominantly professional accounts of member/s of the profession with experience of the expert witness role, some research on the role of medical practitioners and psychologists was evident. For example, Bach and Gudjonsson (1999) and Wingate (2002) gained feedback on the contribution of psychologists and psychiatrists from members of the legal professions using mailed surveys. The study by Bach and Gudjonsson (1999) in the U.K. evaluated the satisfaction of personal injury lawyers with the quality of expert witness reports of psychologists and psychiatrists in civil cases, the majority of which were personal injury cases. Although there was general satisfaction with the reports of both professions, the reports were criticised for their length and the resultant cost, and
for lack of clarity arising from use of technical jargon. The main limitation of Bach and Gudjonsson’s study was the low response rate (15.4%). In the U.S., Wingate (2002) examined perceptions of the federal judiciary about expert opinions of organisational/industrial psychologists. As a result he made recommendations about the science and practices of his specialty in the legal system with practical suggestions regarding the expert witness role. Considered together with Hall-Lavoie’s (1997) study of occupational therapy medico-legal practice in Alberta, Canada, these two studies demonstrate the usefulness of involving legal professionals in research to inform the practices of medico-legal experts in the health professions.

2.8.4 Social Workers and Physiotherapists as Expert Witnesses

Themes of understanding the medico-legal system, writing reports and preparation for the expert witness role are evident in the social work literature (Vogelsang, 2001), and in the physiotherapy literature over the last decade (Dimond, 1999; Hayne, 1995; Schofield, 1999). In the style of Brodsky (1991), Vogelsang (2001) included several practical examples of how social workers can prepare for court and how to phrase their responses during cross-examination, when the expert’s evidence is most likely to be diminished.

Authors on physiotherapy topics, Hayne (1995), Dimond (1999) and Schofield (1999) made a number of points that have application to occupational therapy expert witnesses. Hayne explained the court proceedings in personal injury cases and the role of the legal personnel who are present. Dimond (1999) advised that although called as an expert to assist the court in disputed cases, the physiotherapist should not “see the court battle personally” (p. 181). Schofield (1999) offered advice on various aspects of the medico-legal process and some case vignettes demonstrating the principle that the physiotherapists’ role was to help distinguish fact from fiction. Consistent with other
health professionals, Dimond (1999) reiterated that impartiality and professional integrity would lead to respect from the court and, in addition, stated that this approach would assist the court by saving time. Dimond represented the plaintiff as potentially applying pressure to the physiotherapist to exaggerate his/her claim in order to increase compensation. Notably, the Chartered Society of Physiotherapists (1994) (cited in Dimond, 1999) has developed guidelines for qualifying physiotherapists as expert witnesses. The Chartered Society of Physiotherapists recommendations are that experts have five years of experience in their specialty, hold a senior position in the U.K. National Health Service, have credibility with peers, have published, and have conducted a research project. However, the practicality of these criteria was not examined. For example, the percentage of practitioners who would qualify as experts according to these criteria was not explored. Explicit criteria for identifying experts were not located in the occupational therapy medico-legal literature.

2.8.5 Responses of Health Professionals to the Expert Witness Role

In the foreword to Vogelsang’s book, Brodsky (2001) stated that anxiety, angry resentment and detachment are common emotional responses of mental health professionals called to the witness stand as expert witnesses. Brodsky related anxiety to feelings of inadequate preparation, angry resentment at being forced to compromise between helping the client and the demands of social justice, and detachment once the process had become predictable and repetitive. The medico-legal literature has several other indications of the personal and emotional responses of medical practitioners and mental health professionals to writing medico-legal reports and testifying in court. These authors experienced the expert witness role in a variety of different ways such as: (a) challenging (Allnutt & Chaplow, 2000); (b) “stimulating (and well paid)” (Barrister, 1999, p. 1365); (c) “detest[ed]” (Farrell, 1996); and (d) sometimes accompanied by
feelings of humiliation, distress or ineptness (Brodsky, 1991). These accounts suggest that occupational therapists might experience some or all of these emotional responses in the expert witness role, although this has not yet been determined by research.

2.9 Trends Impacting on Expert Witnesses

Some trends impacting on expert witnesses have been identified. The literature supports trends of referrals to increasingly specialised experts (Cornes & Aitken, 1992; Gore, 1992), and more demonstrable levels of expertise in expert witnesses (Sleister, 2000; Tjiong, 1998). In the U.S., Sleister (2000) indicated that the curriculum vitae of vocational experts should demonstrate they have completed higher qualifications, have conducted research and have peer-reviewed publications, and be able to support their assessment methodology. Sleister linked this trend to the Daubert standard for expert witnesses established in the landmark U.S. Supreme Court case, Daubert v. Merrell Dow Pharmaceuticals (1993) in which the “general acceptance” of an expert’s opinion in a scientific community was replaced by an increased onus on the expert to demonstrate the scientific validity and reliability of an opinion (e.g., the known rate of error of a test). While this case is not directly applicable in Australia, Tjiong (1998) foreshadowed its influence. Freckelton and Selby (2002) predicted the increased use of court-appointed experts. In addition to expressing their own opinions, experts can expect in the future to be asked about an opinion of another expert (Freckelton & Selby, 2002). A more recent inclusion in the medico-legal literature is a process known as “alternative dispute resolution” (Aiken, 2002). This process may include negotiation and mediation. Mediation attempts to gain early resolution to disputes in a non-confrontational manner without recourse to costly legal proceedings (Aitken, 2002; Smart, 2000).
The existing literature does not specifically relate trends impacting on expert witnesses to occupational therapists. However, medico-legal occupational therapists who assess the work capacity of claimants would benefit from knowing about trends likely to impacting on their role as expert witnesses in order to adapt their practices.

2.10 Expert Evidence and Expert Witnesses

The existing literature concerning practice directions for expert witnesses and their evidence provides some general guidelines for occupational therapists relating to the standards for submitting reports and specific rules governing experts and their attendance at court (Alcorn, 1997; Federal Court of Australia, 2004; Freckelton & Selby, 2002; Law Reform Commission of New South Wales, 2004; Supreme Court of New South Wales, 2005; Supreme Court of Queensland, 2005). In general, these practice guidelines state that medico-legal experts must be recognised as experts, be independent and demonstrate they understand that they have a duty to the courts and should avoid the advocacy role. This body of literature also gives insiders’ perspectives on how lawyers select and gain value from expert opinions in civil cases (Cooper, 2001; Freckelton & Selby, 2002; McInnes, 1997), and how to cross-examine experts (Alcorn, 1997; Freckelton & Selby, 2002; McInnes, 1997; M. Perry, 1997; Traves, 2001).

Cross-examination is a critical stage in the medico-legal process. It is the stage in which questions are designed to decrease the credibility of the expert evidence by “cast[ing] doubt on the accuracy of evidence given, or by attempt[ing] to discredit the witness in the eyes of the judge” (Breen et al., 1997, p. 237). The process involves undermining the bases of the expert’s opinion and exploring alternative inferences from the findings (Freckelton & Selby, 2002). Some professional accounts provide lists of
expert witness skills, and responses for cross-examination (Boccaccini, 2002; Brodsky, 1991).

Although preparation for cross-examination is an important consideration for an expert witness, as the numbers of cases going to trial has decreased, greater emphasis has been given to experts’ report writing. Solon (2001) stated, “The expert’s report is now the primary source of expert’s evidence” (p. 764). Freckelton and Selby (2002) stated that the expert’s report “must be written to persuade” and “reflects not only the opinions within in it, but the character of the author” as credible, careful, reliable, and authoritative in his or her field (p. 700). Selby and Freckleton (2002) and Selby (2004) advised that experts should attend not only to the substance of the report but also its presentation should meet the expectations of busy legal professionals. For that reason the format should include headings, dates of a succession of events, and have room for the reader to make notes. The solicitor’s instructions defining the scope of an opinion should be given, and a statement made as to any questions outside their expertise. A summary of the opinion should be provided along with a concluding declaration that all desirable and appropriate enquiries have been made and no significant matters have been withheld. Experts should say if their opinions are provisional and the reasons (e.g., insufficient information) and otherwise qualify them as necessary. Furthermore, Freckelton and Selby (2002) noted the dislike of the courts for “template” experts whose reports differ only in the demographic details and minor respects. Cross-examination may be directed to demonstrating the “fabricated” nature of such reports and that insufficient time has been spent on data analysis and report preparation (Freckelton & Selby, 2002, p. 760). This generic information is an essential guide for occupational therapists but is unlikely to be sufficient when writing work capacity reports.
A number of persistent problems have been associated with expert witnesses, such as the associated costs, delays and debate about value of the evidence provided (Gore, 1992). Brodsky (1991) reminded expert witnesses of the old maxim “whose bread we eat, his song we sing.” Inevitably, some expert witnesses will be perceived as being biased (Farrell, 1996). Freckelton and Selby (2002) confirmed the need for experts to convey the image of being an “impartial, objective observer who has been brought to the courtroom to assist the judge, [or] magistrate” and to expect that the other party will routinely attempt to demonstrate their bias (p. 718). These authors stated that arguments used to reduce credibility and independence of an expert might include (a) the witness is paid by the other party, (b) the witness has given the same testimony on other occasions, (c) the witnesses stance and evidence have been shown to be biased in the past, and (d) the witnesses’s evidence is unrepresentative of the consensus of accepted views on the subject. On the other hand, (Alcorn, 1997), a medico-legal psychiatrist, stated that the issue of bias in expert witnesses has existed at least since the 19th century and has been observed to be “a consequence of the adversarial system” rather than the expert witness’s own choice (p. 11). Saks (1990), a legal professional, also recognised this problem and said there was often “a tension between the role designed and part enacted” by expert witnesses (p. 291). From Saks’ experience and reading, he proposed a conceptual model of four different expert witness roles that were later applied by Harrison (1997) to psychologists working in family law courts. Because of their potential relevance to occupational therapy expert witnesses, these roles are considered in turn.

Saks’ (1990) first role is the “mere conduit/educator” who dispassionately relays knowledge and information from a field of expertise to the court without concern for the moral implications. The occupant of this role provides technically or professionally correct expertise including evidence against the referring side. It is precisely because
the educator is willing to share knowledge frankly with anyone who asks for it that they may be overlooked in an adversarial system where lawyers are seeking a controlling advantage over expert information. Alcorn (1997) and Solon (2001) also said experts had a role in educating the courts, but did not extend their assertions to other aspects of the role described by Saks.

The second of Saks’ roles is the “philosopher-ruler/advocate.” The occupant of this role transfers the clinical role of advocating for certain outcomes for a client to the court with a resultant loss of objectivity and credibility. Only research and findings supporting the cause are shared, and flaws in the data de-emphasised or omitted. In the medico-legal system, Harrison (1997) stated that the partisan role of the advocate supporting the claimant’s cause should be left to the lawyers.

The third of Saks’s role was the “hired gun” who has no vested interest in the outcome of the case other than satisfying the hiring lawyer’s goals and is therefore willing to bias or misrepresent the evidence. Harrison (1997) believed that this role might be adopted by an expert who is misguided about the expert role and has assumed a role more appropriate to that of a lawyer.

Finally, the fourth of Saks’ roles is “expert witness’s heaven on earth.” In this role the expert’s findings are so helpful to a cause that he/she believes that no choices need be made and all findings can be shared openly. However, Saks stated that this pure form of the role does not exist and the conscientious expert witness may find the role conflicts and the ethical dilemmas of the expert witness impossible to resolve. The implication of the observations of Saks (1990), Harrison (1997) and Alcorn (1997) is that occupational therapy medico-legal experts may find they need to balance some role conflicts and ethical dilemmas.

A small body of literature supports the preparation and training of credible and competent expert witnesses. In a report on accessing civil justice in the U.K., Lord
Woolf (1996) stated that professional people who take on responsibilities as expert witnesses need to be trained in the legal system, their role in it and how to present evidence effectively in written and oral forms.

Three related areas of expert witness training have been referred to in the literature. The first area is general guidance about managing anxiety in the courtroom. Freckelton and Selby (2002) noted that “most people are anxious about being a witness” and need to control “performance anxiety” in the courtroom (p. 709). They proposed familiarisation with the courtroom and attending workshops run by some professional associations for improving the expert’s comfort and persuasiveness in the courtroom. Solon (2001) proposed that experts need independent appraisal of their work to reduce their trial-and-error learning. He claimed that training reduces the anxiety associated with cross-examination but, like Freckelton and Selby, did not offer any basis for this claim.

The second area of training relates to credibility. Although Boccaccini (2002) identified that experts with effective and confident verbal and non-verbal communication skills were perceived as credible and persuasive, he was uncertain the extent to which these skills could be modified through training. Perceived credibility of the communicator may have a marked effect on the outcomes of any formal interaction. American research indicated that in Western cultures credibility is related to “perceptions of individual expertise, trustworthiness and dynamism” (Mohan, McGregor, Saunders & Archee, 1997, p. 379). These authors acknowledged that in some contexts, dynamism may be inappropriate if the protocol of the group was to be quiet, reserved and respectful. In the medico-legal system and especially the courtroom, credibility is more likely to be closely related to perceptions of expertise, integrity and adherence to the restrained behaviour consistent with the culture.
The third area of expert witness training relates to detection of deception in claimants during assessment. Hill and Craig (2004) reported on research in which undergraduate students were trained to detect simulated facial expressions of pain. They found that immediate corrective feedback improved detection accuracy, whereas there was no support for an information-based training program.

These three suggested areas of training for expert witnesses are potentially relevant to occupational therapy experts. However, when considered with earlier sections of the literature review, there remains an inadequate understanding of the training needs of occupational therapists who provide expert opinions on work capacity in the medico-legal system.

2.11 Evidence and Expertise

A potential source of confusion for occupational therapy experts on work capacity relates to the use of the term “evidence.” Gillham (2000) distinguished between two lay uses of the word “evidence,” namely, scientific and judicial (i.e., legal) evidence. Scientific evidence refers to the findings of research usually relating to experiments or carefully controlled investigations. Gillham identified that this type of evidence is manufactured as it does not occur naturally. By comparison, judicial evidence already exists and in any cases under investigation “has to be uncovered and tested, usually by reasonable argument” (Gillham, 2000, p. 3). A further distinction needs to be made between evidence generated by research and EBP, which, for the latter, involves the best available evidence being applied to clinical practice interventions (M. C. Taylor, 2000).

With respect to legal evidence, Freckelton and Selby (2002) provided five rules of expert evidence. These are as follows: (a) the “expertise rule,” meaning that the person must have sufficient knowledge and experience to be regarded as an expert; (b)
the “common knowledge rule,” meaning that the information sought from the expert must be more than general knowledge or common sense; (c) the “area of expertise rule,” meaning that the claimed knowledge and expertise must be “sufficiently recognised as credible by others capable of evaluating its theoretical or experiential foundations” (p. 2); (d) the “ultimate rule,” meaning that the expert’s contribution must not answer the question put before the tribunal or court; and (e) the “basis rule,” meaning that the expert should give evidence based on fact and cannot give evidence based on hearsay. However, although opinion evidence is not evidence of fact, experts are given the privilege of providing opinions (Freckelton, 2002). Of relevance to an understanding of legal and scientific evidence is Freckelton and Selby’s (2002) statement that it is the expert’s own opinion that is sought by the courts and they should be careful not to be “a conduit” for an author or researcher who can not be cross-examined (p. 725). In this way, the expertise of individual experts is highlighted.

In contrast, the evidence of experts is the lowest in the evidence-based medicine’s hierarchy of research evidence where systematic reviews of randomised controlled trials (RCTs) are rated as the highest form of evidence (Sackett, Strauss, Richardson, Rosenberg, & Hayes, 2000). This hierarchy implies that opinions of an individual expert are less valuable. More recently, although the hierarchy of evidence has remained, definitions of EBP have begun to incorporate broader dimensions. Sackett et al. (2000) expanded the definition of EBP in clinical practice to incorporate the conscious and judicious use of relevant and current research evidence, clinical expertise, and patient’s values and preferences. Tonelli (1999) pointed out that there are many inconsistencies in the inclusion of clinical expertise in definitions of EBP but devaluing expert evidence. This confusion about evidence may extend to the courts.

EBP is widely promoted in the occupational therapy profession (Cusick & McCluskey, 2000; McKenna et al. 2004). However, the application of the medical
research hierarchy of evidence, especially the use of RCTs, to occupational therapy has been questioned (Hyde, 2004; Tse, Blackwood, & Penman, 2000). Hyde (2004) stated the evidence hierarchy needs to be applied with caution to occupational therapy which deals with multifactorial issues in a person’s life in the community. Hyde also queried whether statistical probability of RCTs can be used as evidence and reasoned that findings that are true for a population may be “meaningless for the individual” (p. 92). With a similar focus on individual clients, the CAOT, Association of Canadian Occupational Therapy University Programs, Association of Canadian Occupational Therapy Regulatory Organisations, and President’s Advisory Council of the CAOT (1999) defined evidence-based occupational therapy as “client-centred enablement of occupation, based on client information and a critical review of relevant research, expert consensus and past experience (p. 267). Furthermore, Rappolt (2003) proposed a rearranged CAOT model whereby professional expertise has a primary encompassing role in the use of client evidence, clinical decision-making and research evidence. Despite an increased focus on EBP in medical and allied health practice, Chan, Lee, Tsang-Li, and Lam (1999) found that RCTs were not commonly used in work rehabilitation research on cumulative trauma disorder or low back pain and suggested that evidence accumulated by the Cochrane Collaboration focussed on causes of impairments rather than the consequences and resultant disabilities. Rosenwax, Semmens, and Holman (2001) recommended that occupational therapists apply evidence-based guidelines developed by other professionals as an interim solution until guidelines were developed by occupational therapists. For example, they applied The Australian Faculty of Musculoskeletal Medicine’s clinical guidelines for the treatment and management of acute low back pain (Bogduk, 1999) to occupational therapy practice. These findings suggest that there is an underdevelopment of EBP on which
occupational therapy experts in work capacity can draw and a potential limitation in applying the principles of EBP to expert opinions on work capacity.

2.12 Expert Witnesses and Claimants/Plaintiffs

The relationship between health outcomes following injury or illness and individuals’ compensation status has been extensively examined in the literature. There has been speculation as to whether litigation decreases the likelihood of a successful outcome (Barraclough, 2001; Carrick, 2001). While the Royal Australasian College of Physicians (2001) published an extensive and authoritative study illustrating the negative effects of compensation claims on the health outcomes of claimants, a smaller body of literature has shown compensation status to have no effect on treatment response (Mayer, McMahon, & Gatchel, 1998). To advance an understanding of the relationship between compensation status and health outcomes, R. C. Tait (2004) proposed that compensation and litigation inadequately explained health outcomes for people with chronic pain. Instead, R. C. Tait identified a complex relationship between the following: (a) injury-related stress (e.g., pain, emotional distress, physical incapacity, role change); (b) individual vulnerabilities (e.g., coping resources, beliefs, expectations); and (c) compensation-related stress (e.g., job inflexibility, stigma, financial hardship, litigation). The inconsistency in the literature suggests that experts may have different attitudes and beliefs about claimants and their health outcomes.

Other related and recurrent themes in the medico-legal literature are the motives of claimants with respect to increasing their compensation, and how best to detect symptom magnification and malingering. The mutual honesty between a medical practitioner and patients is replaced by the need to avoid being deceived in the medico-legal system (Breen et al., 1997; Blau, 1998). Malleson (2002), a psychiatrist for the defendant, expressed the attitude that many whiplash claims have a spurious basis to
them. Despite concerns about malingering in the workers’ compensation system, an investigation of deliberate attempts to defraud by mimicking conditions suggest it is relatively rare, that is, less than 5% of cases (Fraser, 1996; Isernhagen, 2001; Sullivan, 2004). Cornes (1997) found references to “compensation neurosis,” “secondary gain,” and “actual or suspected exaggeration of symptoms or residual disability in order to increase the amount of compensation received” in claimants were unduly emphasised (p. 365). Large, New, Strong, and Unruh (2002) proposed that malingering is a label that should be cautiously applied and is dependant on demonstration of deliberate deception. Another mechanism has been proposed as an alternative to deliberate deception. Blau (1998) stated that “the emotional effects of litigation procedures can distort the presence and degree of disability” (p. 268). This literature suggests that medico-legal experts need to be alert to a range of possible claimant explanations for claimant responses and presentations.

A number of attempts have been made to develop or adopt criteria to guide medical experts to identify malingering in medico-legal claimants. Chapman and Brena (1990) identified the characteristics of people with low back pain who produced inconsistencies between self-report and observed behaviours. Characteristics of people with inconsistent presentations relevant to occupational therapists assessing work capacity in the medico-legal system include (a) pending litigation, (b) increased focus on pain and dramatisation of pain with increased use of affective descriptors, (c) fewer consistent medical findings, and (d) lower levels of activity. However, Abdel-Moty et al. (1996) compared the perceived (stated) levels of function and measured (observed) levels of function in 20 patients with chronic low back pain and 20 healthy volunteers on stair climbing and squatting. Self-report was used to explore perceived functional limitations and psychosocial factors such as attitudes to pain and illness behaviours, self-efficacy, and emotional states in order to prepare suitable rehabilitation. They found that both healthy
subjects and those with low back pain underestimated their actual levels of function. As the patients with low back pain were not involved in litigation, the findings suggest that underestimation of ability may be common, and both self-report and observed performance are required in the assessment of actual physical abilities.

Some authors have proposed that detection of malingering is difficult with a single psychological test or formula (Blau, 1998). Instead, some clinicians have used Waddell’s (1998, 2004) criteria of non-organic signs of disability to determine genuineness in the medico-legal system. Waddell’s criteria include: abnormal tenderness, abnormal response to simulated body stress, variations from normal straight leg raising responses, and regional disturbances of sensation and movement. Critics such as Fishbain, Cutler, Rosomoff, and Steele Rosomoff (2004) have stated that these criteria are inappropriately used in the medico-legal system for the detection of malingering and secondary gain. In addressing the critics, Waddell (2004) asserted that provided the strengths and limitations of the non-organic signs were understood, they make an important contribution to understandings of illness behaviour in chronic pain cases.

Some literature has conceptualised medico-legal assessments within broader rehabilitation, historical or social contexts. Schultz, Crook, Fraser, and Joy (2000) identified that proponents of each model of diagnosis and rehabilitation would have different values impacting on clinical practice and attitudes to compensation claimants. Proponents of these models, namely, biomedical, psychiatric, insurance, labour relations, and biopsychosocial, may hold different attitudes regarding chronic pain, and the benefits of rehabilitation in the medico-legal system. In contrast to the literature proposing that malingering can reliably be detected, Mendelson and Mendelson (2004) conducted a review of historical approaches and relevant research and concluded that there are “no valid clinical methods of assessment of possible malingering of pain” (p. 423). These authors emphasised that malingering was a legal decision for which the courts had
responsibility to undertake fact-finding, and health care professionals should avoid giving an opinion on the veracity of the plaintiff. Sullivan (2004) had a slightly different approach and proposed that malingering is a social and moral standard but, consistent with Mendelson and Mendelson, concluded that “pseudoscientific reliance on medical tests” to detect it is misplaced (p. 433). These views add to the range of divergent attitudes and approaches expressed by other authors on the assessment of claimants/plaintiffs in personal injury cases. The views signal that assessment of personal injury claimants may be complex and difficult for occupational therapy and other medico-legal experts, and require additional expertise to that needed for the rehabilitation context.

2.13 Conclusions Regarding Perspectives from the Literature

The body of literature reviewed indicates that occupational therapists have intermittently published on medico-legal aspects of work-related practice over the past three decades, principally from the perspectives of individual members of the profession. A smaller body of occupational therapy literature provided guidelines based on the views of a number of occupational therapists. However, this literature review generally demonstrated that the extent of research on the current research topic is limited, necessitating the review of related bodies of literature, namely, work-related assessment issues and health professionals as expert witnesses. This literature review revealed numerous publications about the measurement principles of FCEs and the many complexities inherent in the assessment of claimants in the medico-legal system. In the absence of literature specifically about the medico-legal system, it appears reasonable to conclude that the main choice of assessment tools for occupational therapists are standardised marketed FCEs, although some more recent research has not supported this assumption.
From a wider body of literature about the use of expert witnesses to advise the courts, literature was identified relating to the use of medical and allied health experts in personal injury cases. This literature confirmed the need for health professionals to prepare expert opinion reports that withstand rigorous appraisal by lawyers, particularly under cross-examination. The literature emphasised the need to understand one’s own professional assumptions, reasoning processes, evidence and areas of expertise, and be conscious of the need to counteract systematic biases in favour of the referrer.

Within the literature for expert witnesses in the health professions are some guides that are comprehensive and informative, although the content is frequently profession-specific. Without such literature occupational therapists need to extrapolate from the experiences of other health professions, especially medical specialists, and attempt to understand the perspectives of the legal professionals. While some of this literature is undoubtedly helpful, commentary about profession-specific opinions of work capacity, assessment methods and ways to prepare for the role of expert witness is limited and requires systematic research to adequately address these issues. The researcher contends that the lack of relevant literature makes the provision of expert opinions on work capacity more difficult for occupational therapists in the medico-legal specialty. It is timely that occupational therapists have substantive information that applies directly to their own profession and specifically to expert opinions on work capacity.

2.14 Directions of Future Research

In summary, an extensive literature review identified that no examples of research-based evaluation of the contribution of occupational therapists to medico-legal decisions about work capacity currently exists. As this information can not be obtained from experimental designs and the field of enquiry is complex, a qualitative approach is
required. Specifically, it would be valuable to obtain the experiences and perceptions of occupational therapists and stakeholders with direct experience of occupational therapy contribution to the medico-legal decisions on work capacity in order to develop a thorough understanding of the research topic. As suggested by the literature, occupational therapists with medico-legal experience, lawyers and medical specialists are the key stakeholders who are directly involved and able to provide this information.

2.15 Research Aims and Research Questions

As critical evaluation of the profession’s contribution is absent from the literature this research has a number of related aims and questions. The following research aims and questions emanate from the literature review.

1. To understand the contribution of the occupational therapy profession to medico-legal decisions about work capacity;
2. To identify current occupational therapy medico-legal work capacity evaluation and expert witness practices; and
3. To identify strategies to improve occupational therapy expert opinions on work capacity.

The research will address the following questions:

(a) What are the experiences and perspectives of occupational therapists providing expert opinions on work capacity?

(b) What are the experiences and perspectives of members of legal and medical professions who request and/or peruse occupational therapists reports about their clients’ or patients’ work capacity?
(c) What are the assessments of physical, cognitive and psychosocial function that occupational therapists report to the courts and what is the basis for their inclusion in the assessment of work capacity?

(d) How is quantitative and qualitative information in occupational therapy reports interpreted by the courts?

(e) What information and education do occupational therapists need to improve their expert opinions on work capacity? and

(f) What grounded theory of occupational therapy contribution to medico-legal decisions about work capacity is embedded in the data?

The current chapter concludes Part A, the introduction to the thesis. In Part B, the research design and process chosen to examine the research topic are explained and justified. Specifically, Chapter 3 presents details of the research methodology and methods, and Chapter 4 presents details of the participants and ethical considerations in the research.
PART B: THE RESEARCH DESIGN AND PROCESS

CHAPTER 3
METHODOLOGY AND METHODS

3.0 Introduction

In Chapter 3, the selection of research design will be supported and the research process outlined. In particular, the methodology and the methods will be considered. The methodology, or philosophical considerations of the research design (Hammell & Carpenter, 2000), will be explained along with its assumptions. The methods used for data collection and data analysis will be described in detail and related to the research design and findings. The methods are a set of procedures or techniques chosen for their compatibility with the methodology design (Hammell & Carpenter, 2000). Strategies used to ensure that the research was undertaken rigorously will also be outlined. The details of participants, their recruitment and ethical considerations will be specifically addressed in Chapter 4.

3.1 The Qualitative Research Paradigm

As there was no existing explanatory theory about the contribution of occupational therapists to medico-legal decisions about work capacity, the researcher sought an authentic, multifaceted representation of the research topic through listening to the views of participants from three professional groups directly involved in the process. Therefore, the research design was formulated in the qualitative research paradigm.
A qualitative research design has a number of advantages for the current phenomena under investigation. First, a qualitative research design is best suited to complex and ambiguous social situations and systems, such as the medico-legal system, “where it is not easy to identify ‘variables’ let alone measure them” (Dick, 1999, p. 4). Second, a qualitative research design can be used to gain insight into naturalistic processes (e.g., interactions between stakeholders in personal injury cases) that are not readily researched in artificial or experimental settings by quantitative methods (Pope & Mays, 1999). Third, a qualitative research design has an advantage in those studies in which expression of information in numeric terms would result in a loss of complex and subtle information. For example, counting the number of times that occupational therapists write medico-legal reports on work capacity would not provide an insight into the value of their contribution. Fourth, qualitative research is an inquiry process used to explore “a social or human problem” (Creswell, 1998, p. 15), such as the challenges of identifying the work capacity of claimants with work-related injuries. In general, a qualitative research methodology affords comprehensive lines of inquiry about elusive social behaviour and experiences, and, correspondingly, a broad conceptualisation of the problem.

Three characteristics of qualitative research noted by Morse (1992, p. 1) are incorporated into this research. The first characteristic is the “emic” or insider’s perspective that elicits meaning, experiences or perceptions of the participants. The second characteristic is the “holistic perspective” including context and underlying values as part of the phenomena of interest. The third is the “inductive and interactive process of inquiry” between the researcher and the data (Morse, p. 1).
3.2 **Grounded Theory: Purpose and Development**

The principles of qualitative research outlined in the two preceding paragraphs apply to a number of qualitative research methodologies. Grounded theory, “one of the major schools of qualitative inquiry” (Patton, 2002, p. 56), has some features that are particularly applicable to this research.

Grounded theory is a theory-generating methodology in which research findings are systematically examined for a theory embedded in the data. B. Glaser and Strauss (1967) developed the approach to manage research data and discover theory embedded therein, and subsequently termed the approach “grounded theory.” A grounded theory is “discovered, developed and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (Strauss & Corbin, 1990, p. 23). Based on the Oxford English Dictionary (1989), a theory is a system of ideas or statements of general principles held as an explanation or account of known or observed phenomena or a group of facts. Although researchers may be informed about a range of theories in related areas of literature and from their knowledge and experience, this should not restrict openness to new theories emerging from the data (Strauss & Corbin, 1998). Theoretical sensitivity is the term used for this process (B. Glaser & Strauss, 1967). Therefore, a grounded theory methodology can be contrasted with other qualitative research methodologies in which the aim is to describe and understand, but not necessarily to theorise about, the meaning of the experiences and perceptions for the participants. In grounded theory research the qualitative data are systematically analysed to develop a theory that is grounded in that data (Creswell, 1998).

Grounded theory is particularly suited to those situations involving formulation of theory about social processes, that is, the actions, interactions or responses of people to a particular phenomenon (B. Glaser & Strauss, 1967; see also Creswell, 1998; Seale
& Barnard, 1998; Strauss & Corbin, 1998). The meaning of a social situation must be gained from people involved in the social interaction rather than from observation or pre-existing theory alone.

The researcher chose grounded theory methodology to identify concepts related to expert opinions on work capacity, and from these aimed to construct a mid-range theory that would be useful in explaining and guiding relevant occupational therapy practice. A mid-range theory is one that has a moderate range of applicability rather than a “grand” or macro-level theory that has universal application, or an elemental micro-level theory that has only local application (Fitzgerald, 2001). “Mid-range” theories are “theories that guide professional practice at the most general level … for example, theories about how specific systems operate” (Fitzgerald, 2001, p. 172).

Grounded theory is informed by symbolic interactionism through the work of Mead, Blumer and other sociologists, social psychologists and philosophers (P. L. Rice & Ezzy, 1999; Stanley & Cheek, 2003). Symbolic interactionism is based on a philosophical stance that people are shaped by their social interactions, internalise symbols of the social world and act upon the basis of the shared symbols (Blumer, 1969; see also P. L. Rice & Ezzy, 1999). Informed by symbolic interactionism, grounded theorists assume that people make sense of and perceive an order in a world that may not be orderly (Stanley & Cheek, 2003). Based on symbolic interactionism, the patterns of meaning that participants in the current research ascribe to occupational therapists’ contribution to the medico-legal system will be informed by their experiences and perceptions of the phenomena being studied.

3.3 Grounded Theory in Socially-focused Disciplines

Grounded theory is used to generate theory about complex social situations. Due to its emphasis on human interactions, grounded theory has been used extensively
in the socially-focussed disciplines of occupational therapy, education, nursing and sociology (Creswell, 1998; P. L. Rice & Ezzy, 1999; Strauss & Corbin, 1994).

Hammell and Carpenter (2004) and Stanley and Cheek (2003) supported the use of grounded theory by occupational therapy researchers where few adequate theories exist to explain or predict the behaviour of a group. Stanley and Cheek examined 18 occupational therapy studies that used grounded theory to develop a theory and/or model to guide the profession. In two examples related to the research topic, Dubouloz, Egan, Vallerand, and von Zweck (1999) explored occupational therapists’ perception of EBP and discovered three broad inter-related categories of perceptions held about it, and Cusick (2000) explored the experiences of “research-productive practitioner-researchers” and identified six conceptual categories describing their experiences. Of particular relevance is the research of Tse and Yeats (2002). These authors appear to be among the first in the occupational therapy literature to have used a grounded theory methodology to explore work-related practices. Tse and Yeats (2002) identified a theory of how people with bipolar affective disorder achieve success in employment. Tse and Yeats’ theory consisted of two principles of workforce participation. The first principle related to the recovery of the person with bipolar affective disorder, and the second to compatibility between the person, their job, support network and contextual features. Grounded theorists may take several pages to fully explain their theory and often represent it graphically with a diagrammatic model (e.g., Dubouloz et al., 1999; Tse & Yeats, 2002).

Examination of the use of grounded theory in the health and rehabilitation literature revealed that grounded theory was used by Shepard, Hack, Gwyer, and Jensen (1999) to theorise about the nature of clinical expertise in physiotherapy. These authors concluded that grounded theory was effective in exploring complex issues of clinical expertise and providing a theory that contributed to EBP. Shepard et al.’s focus on
clinical expertise in physiotherapy treatments means that the theory is not transferable to occupational therapy medico-legal assessments and opinions. However, the study supports the use of grounded theory in exploring areas of professional expertise in the health professions. Therefore, these documented examples of socially-focussed research in peer-reviewed journals provide precedents for the adoption of grounded theory methodology for research that will explore the roles, interactions and processes relevant to occupational therapists providing expert opinions on work capacity.

3.4 Grounded Theory Variants and Features

A number of variants of grounded theory have evolved from symbolic interactionism perspectives and are described by a number of authors including Charmaz (2000, 2002), Grbich (2004), Kendall (1999), Patton (2002), Seale and Barnard (1998) and Stanley and Cheek (2003). Grbich (2004) noted that grounded theory is a popular methodology used in health research “in both its pure and adapted forms” (p. 158). Variants of grounded theory methodology relate to assumptions concerning the extent to which reality is subjectively or objectively knowable, the role of pre-existing theory, and strategies for data analysis. Two principal variants are associated with each of the founders, B. Glaser and Strauss (1967). Since their foundational statements in 1967 B. Glaser and Strauss have each developed grounded theory in slightly different ways.

The Glaserian variant is comprehensively described in B. Glaser (1978, 1992, 1998), and B. Glaser and Strauss (1967). B. Glaser emphasised that grounded theory emerges from the data, and categories are not informed by pre-existing theory (Kendall, 1999). In the current research and in keeping with the Glaserian variant, the grounded theory was allowed to emerge from the data through constant comparison of data, and
reading of pre-existing theory was limited until a grounded theory emerged. Although B. Glaser’s (1978) aim was to ensure that the researcher had freedom to identify a grounded theory from the data, he proposed a number of coding families or paradigms to focus the data analysis. The basic social problem and basic social process are two of the 18 coding families that he proposed. A basic social process is undertaken to resolve a basic social problem or main concern shared by the participants (B. Glaser, 1978, 1998, 2001). In the present study, the basic social problem for the participants was co-constructed by the researcher and participants as the medico-legal system’s need to deal fairly and economically, on behalf of the community, with people with work-related personal injury claims. The basic social process driving participants’ actions to resolve this problem was identified, through the researcher reflecting on the shared problems of the participants, as the medico-legal system’s use of occupational therapy experts in work capacity to assist in making decisions about rehabilitation, compensation, economic loss and employment discrimination in relation to claimants.

The Straussian variant is described in detail in Strauss and Corbin (1990, 1998). These authors have added dimensionalising, verification, axial coding and a conditional matrix to their variant. Of these, Kendall (1999) proposed that axial coding was the major point of variation between the Glaserian and Straussian variants and suggested that researchers choose between these two variants based on the goal and needs of the research. Features of the Straussian variant were incorporated into the current research to handle voluminous data and to ensure the relationships between data categories and sub-categories were examined systematically during axial coding. In addition, Strauss and Corbin (1998) described an axial coding paradigm to assist with data analysis during the axial coding. Applying the axial coding paradigm involves examining each category and sub-category in terms of conditions, actions and interactions arising under the conditions, and the consequences of the actions/interactions. However, Kendall
(1999), Charmaz (2000) and Robrecht (1995) considered that applying the axial coding paradigm added unnecessary restrictions and complexity to data analysis, and placed attention on procedures while distracting from the interpretation of the data and emergence of an integrated grounded theory. In the current research, Strauss and Corbin’s (1998) paradigm was applied broadly to the findings and this was found to be useful in conceptualising and interconnecting the four categories of findings.

The first category of data was found to relate to the medico-legal system (i.e., the set of conditions in which expert opinions on work capacity are provided). The second category relates to occupational therapy expert opinions that assist the courts (i.e., actions and interactions between occupational therapists and other stakeholders with the aim of occupational therapists contributing valued opinions). The third category relates to assessing, forming and reporting expert opinions in response to requirements of the medico-legal system (i.e., more specific actions and interactions). The fourth category conceptualises how to prepare for the future (i.e., these are the consequence of participants’ identifying trends in the medico-legal system and the ways to improve occupational therapy expert opinions).

More recently, Charmaz (2000, 2002) further distinguished between objectivist and constructivist forms of grounded theory. She cited Strauss and Corbin (1990), B. Glaser and Strauss (1967) and B. Glaser (1978) as examples of objectivists who assume that “data represent objective facts about the knowable world” (Charmaz, 2002, p. 677). In contrast, in her development of the constructivist form, Charmaz emphasised that interviews collect participants’ views of reality and the researcher interprets these views. After reflecting on the goals and needs of the current research (Kendall, 1999), the researcher selectively incorporated features of the grounded theory variants of Charmaz (2000, 2002) B. Glaser and Strauss (1967), B. Glaser (1978, 1992), Strauss and Corbin (1990, 1998) into the design and process (see Table 2 for these features).
Table 2
Features of Grounded Theory Used in the Current Research

1. The literature review was not completed until a grounded theory had emerged;
2. In-depth interviews were the primary data collection method;
3. Reflection on the collected data informed theoretical sampling of participants;
4. Conceptual categories of data were first proposed after initial data collection;
5. Data collection and analysis occurred simultaneously;
6. Multiple levels of coding (i.e., open, axial and selective) were used to identify and relate conceptual categories of data;
7. Categories and sub-categories of meaningful data were progressively refined and defined throughout data analysis by constant comparison and questions (in memos);
8. Data collection ceased when categories were saturated (i.e., no new categories were emerging and a complete and robust theory was evident);
9. The basic social problem and basic social process were co-constructed with participants;
10. Relationships between categories and sub-categories were made explicit as a grounded theory;
11. Through a process of increasing abstraction a grounded theory was identified and expressed as four sets of distinct but interrelated theoretical formulations;
12. The grounded theory was returned to participants as key findings for verification;
13. The core category of the grounded theory was compared with relevant literature;
14. The researcher had a role in data collection and interpretation.
Consistent with Charmaz’s variant, Hall and Callery (2001) proposed that grounded theorists account for their own stance and their relationships with the participants (reflexivity), especially issues of power and trust (relationality). These features are addressed throughout the current research.

3.5 Data Collection

Data collection is the first of two main phases of the research process, the other being data analysis. In-depth interviews were the primary means of data collection in the research. In-depth interviews enabled the researcher to follow more subtle and flexible lines of enquiry when compared to survey methods. Creswell (1998) identified that interviews are the primary method of data collection for the development of grounded theory. A secondary method of data collection was a Researcher’s Journal in which Field Notes and Memos were written (see section 3.5.3).

Interviews are a preferred data collection method in qualitative research as they enable the researcher to get close to the meanings and interpretations that participants’ ascribe to a social situation (Blaikie, 2000; Minichiello, Aroni, Timewell, & Alexander, 1996). Furthermore, interviews enabled the researcher to learn about those events and activities that could not be directly observed (S. Taylor & Bogdan, 1998).

3.5.1 The Interviews

The interviews in this research shared a number of features. They were in-depth, that is, focussed (Minichiello et al., 1996), and intensive interviews (Law et al., 1999). As focussed interviews they had one main topic (P. L. Rice & Ezzy, 1999), which was occupational therapists’ contribution to medico-legal decisions about work capacity. As intensive interviews they were time efficient, semi-structured in format using open-ended questions to allow exploration of points of importance and obtain maximum
information. Open-ended questions enable adequate exploration of the issues from the perspective of the participant (Britten, 1999).

The interviews were all completed by the researcher throughout a period of 26 months between December 6, 2000 and January 29, 2003. Interviews were conducted at a time and place convenient to each participant. A total of 30 in-depth interviews were conducted with 31 participants. At the participants’ request, one dual interview was conducted face-to-face with a solicitor and an occupational therapist working in the same organisation. A number of ethical considerations were applied to the interviews with the participants and throughout the research (see section 4.5 for Ethical Considerations Regarding Participants).

During all communication preceding and during the interviews, care was taken to develop trust and rapport with participants in order to more fully explore some of the complex and sensitive issues in a safe environment and constructive manner during the interviews (e.g., perceptions of bias in occupational therapists’ reports, and attitudes to assessments in the medico-legal system). The researcher consciously related to all participants as equals and respected and accepted individual experiences. The foundations for open communication began when communicating with prospective participants during the recruitment phase (for the recruitment strategy see section 4.3).

In general, occupational therapists were willing to participate and interviews with them were readily arranged. This was attributed to trust and rapport existing between members of the same profession, and to their interest in the research topic. When contacting lawyers and medical specialists who were prospective participants, the name of a high profile member of the same profession who had recommended the participant was quoted, where possible. This approach appeared to facilitate an introduction to these groups of participants and so was consistently used to gain interest in the research. Trust is facilitated if the person who introduces the participant is trusted
by him/her (P. L. Rice & Ezzy, 1999). At the invitation of secretaries, one to four telephone calls were required to make an interview time with participating lawyers and medical specialists. After the first two interviews with occupational therapists and the first interview with a lawyer and a medical specialist, subsequent participants were sent either the Interview Guide for Participant Occupational Therapists (see Appendix E) or Interview Guide for Participant Medical and Legal Professions (see Appendix F). This was done to assist participants prepare through reflection on the cues prior to the interview, and so increase the quality of data gained.

The in-depth interviews took between 45 minutes and 2 hours. Each participant was interviewed on one occasion. As short breaks in the first interview proved useful in allowing the researcher and participant to reflect on additional topics that each wanted to address, this practice was subsequently adopted when it suited the participant. In excess of 40 hours of audio-taped interviews were recorded. A summary of the settings, methods and duration of the interviews appears in Table 3.

Interviews were conducted face-to-face, except for six instances. In these instances, the interviews were conducted by telephone because face-to-face interviews were not feasible. The inclusion of participants who were accessible by telephone extended the number of experiences and perceptions that could be examined from different geographical locations, in circumstances in which funding was not available for intrastate and interstate travel (Seale & Barnard, 1998). Three of the telephone interviews were conducted with participants more than 16-hours drive away. In most respects the telephone interviews were conducted in an identical manner and similar duration to the face-to-face interviews. Some particular difficulties, such as lack of non-verbal communication leading to briefer contact, have been associated with research interviews by telephone (Gillham, 2000). However, this did not appear to be a barrier to good communication in the current research. In the telephone interviews, rapport was
readily established. One sign of good rapport was the way informal discussion continued with one medical specialist for 10 minutes after the formal part of the interview had been completed, and the interviewee sent a letter of thanks on receipt of his interview transcript. Although the non-verbal aspects of communication can be problematic for telephone interviewers and interviewees (Gillham, 2000), the researcher did not find this occurred when interviewing participants whose professional work requires proficiency in communication on the telephone.

Table 3
Summary of Interviews with Participants: Settings, Methods and Duration

<table>
<thead>
<tr>
<th>Interview details</th>
<th>Profession of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Occupational therapist (n=19)</td>
</tr>
<tr>
<td>Interview setting</td>
<td>Participant’s office</td>
</tr>
<tr>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Interview method</td>
<td>Face-to-face</td>
</tr>
<tr>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Interview length</td>
<td>Range (hours)</td>
</tr>
<tr>
<td></td>
<td>0.75 - 2</td>
</tr>
<tr>
<td></td>
<td>1 - 1.75</td>
</tr>
<tr>
<td></td>
<td>1 - 1.5</td>
</tr>
</tbody>
</table>
Before each telephone interview commenced the researcher explained to the participant the contingency plan if technical difficulties arose during the telephone interview. On one occasion the technical difficulties of interviewing a participant while travelling in a moving car could not be resolved and a face-to-face interview was scheduled instead. Participants were invited to ask for repetition or clarification if the questions or comments were not clearly heard or understood. Any difficulties the interviewees may have experienced with the telephone interview medium appeared to be outweighed by the opportunity to express their opinions, assured of confidentiality, and with reduced visual distractions.

All interviews were audio-taped with the prior knowledge and consent of participants. A speaker phone was used for the telephone interviews so that the interview could be recorded. The audio-taped interviews were transcribed by a research assistant before thorough editing by the researcher while listening to each interview. Transcripts were then returned to each participant. Participants were invited to remove any remaining identifiers, and, if necessary, edit the transcript to ensure it reflected their experiences and perceptions. No participant requested changes to the transcript.

In preparing transcripts, Browne (2004) advised researchers to decide whether to “clean up” quotes for publication (p. 659). Some segments of transcripts were modified in order to increase coherence and readability. The major portion of this data cleansing process was undertaken prior to transcripts being returned to participants. Consistent with Browne (2004), the purpose was to give participants the opportunity to ensure that the intended meaning was not altered. Examples of data cleansing are: (a) removal of incomplete sentences if they were immediately reworded and completed by the participant; (b) removal of excessive numbers of “you know,” “I guess,” “right,” “Okay,” “well,” “umm,” if they distracted from the flow of the sentence; (c) change of prepositions such as “that” to “who” when people were the subject; (d) change of
singular to plural form of personal pronouns or nouns and vice versa for consistency (e.g., “their” to “his/her”). These minor verbal errors are often embarrassing when transcripts are viewed by interviewees. Four participants who specifically commented on the data cleansing said that they welcomed the changes.

3.5.2 The Interview Guide

The Interview Guide consisted of a list of general topics and issues to be explored during the interview (Minichiello, Madison, Hays, & Parmenter, 2004; Patton, 2002; P. L. Rice & Ezzy, 1999; S. Taylor & Bogdan, 1998). The Interview Guide was developed to represent the research parameters and lines of inquiry for the approval of the University of Queensland Ethics’ Committee, the participants’ information, and as a prompt for the researcher during interviews. The Interview Guide was prepared in two versions with identical prompts but with subtle differences in wording for appropriately addressing occupational therapists and the medical and legal professionals (see versions of the Interview Guide in Appendices E and F). There was sufficient flexibility to allow the researcher to pursue issues that each participant’s experience suggested and that would give an understanding of issues relevant to the general aims and specific questions of the research. In response to each participant, the sequencing and phrasing of the questions varied from interview to interview. Probing questions were used as supplementary questions to further explore or clarify information provided by the participants (Gillham, 2000; Minichiello et al., 2004; S. Taylor & Bogdan, 1998).

The Interview Guide was reviewed after the first three interviews. Strauss and Corbin (1990) noted that questions might “get dropped, or seem less salient, or at least get supplemented” (p. 183). The researcher needs to continually ask questions of the participants to assess the relevance of and relationship between the emerging conceptual categories (Strauss & Corbin, 1998). Two examples reflect these principles. First, as some
sub-categories regarding the choice of FCEs became saturated, increased attention was
given to the relationship with other sub-categories such as how information from FCEs
was used to form an opinion. Second, after some early participants spoke of changes in the
medico-legal system, a question was added to assist the researcher to understand medico-
legal trends with implications for occupational therapy practice.

3.5.3 Researcher’s Journal: Field Notes and Memos

The researcher’s journal recorded supplementary sources of data in the form of
field notes and memos. In excess of 100 pages of memos and field notes were recorded.

Field notes are comments related to interviews such as the process for arranging
interviews, descriptions of interview settings, references to non-verbal communication,
impressions gained from the interview, and ideas for modifying the Interview Guide.
Field notes recorded the sequence of communication with each participant from initial
contact to verification of the key findings. Field notes assisted in the interpretation of
data collected at interviews. One example in this category is the following field note:

“Medical specialists acted in a collegial manner to the researcher and their strategies
for how occupational therapists could improve their expert opinions and wording in
expert reports appeared well intentioned despite the occasional criticism of some
individual reports.”

Memos are “the researcher’s record of analysis, thoughts, interpretations,
questions, and directions for further data collection” (Strauss & Corbin, 1998, p. 110).
They are an essential part of theory generation (B. Glaser, 1978), and provide material
for writing about the findings (Charmaz, 2002). Memos kept in the researcher’s journal
recorded: (a) methodological decisions (e.g., reasons for the direction of theoretical
sampling); (b) questions and ideas to develop the conceptual categories (e.g., “What
were the interactions between occupational therapists and other key stakeholders?” and
“How do their informal and formal interactions differ?”); and (c) reflections and insights on emerging results of data analysis, including a series of diagrams or conceptual maps with analytical commentaries on the relationships between conceptual categories of data. The final version of the diagram (see Figure 1, p. 361) was sent to the participants as an “Overview of the Contribution of Occupational Therapists to Medico-legal Decisions about Work Capacity” as part of a process of initial verification of the grounded theory (see Appendix J4).

Other memos were prompted by knowledgeable informants who were not participants in the research. The researcher was fortunate to be able to confer with a number of key informants who prompted fertile lines of thought or avenues for locating participants. Knowledgeable informants included two professors of law, a barrister, a professor of medicine and a public health physician with an interest in medico-legal issues, and three occupational therapists who were grounded theorists. S. Taylor and Bogdan (1998) noted that the researcher’s journal is a useful place in which to record memos of conversations with knowledgeable informants outside the interview situation. All recorded memos were re-examined periodically between 2000 and 2005 to inform data collection and data analysis, but were not analysed formally with the interview data.

In grounded theory, research data collection continues until theoretical saturation of the categories occurs, that is, until no new categories are found in the data (B. Glaser, 1978), or when data collection processes do not substantially change the theory being developed (Taber, 2000). After theoretical saturation occurred, the researcher’s focus turned to data analysis which is the second of the two main phases of the research process.
3.6 Data Analysis

This section describes how data were analysed and managed during four stages to develop a grounded theory. Systematic and comprehensive data coding associated with grounded theory was the primary analytical method used in this research. Data coding began with assigning conceptual labels to individual words, phrases, sentences or paragraphs and progressed to more abstract coding of groups of categories, until eventually four conceptual categories were integrated as a grounded theory around a core category of data. Categories represent the “problems, issues, concerns and matters that are important” to the participants (Strauss & Corbin, 1998, p. 114). Although presented here as four separate stages of analysis, these stages occurred in an iterative process. A principle of grounded theory data analysis is that it commences during the interview phase of the research (Strauss & Corbin, 1998). In the current research, data analysis not only shaped the selection of participants but also modified the interview format.

In the first stage of analysis, categories of information were developed in a process known as “open coding” (Strauss & Corbin, 1998). A feature of open coding is the repeated examination of units of textual data for salient concepts evident in the text, and assigning a label to them. In this way, 40 labels or codes were recognised (see Appendix H for the list of open codes). Constant comparison is the term used for the process of searching for instances of meaningful text that either represent or do not represent the concepts in order to clarify and to define categories (B. Glaser & Strauss, 1967). For example, the views of each participant about occupational therapists’ areas of work capacity expertise were constantly compared with those of other participants and provisionally labelled “function” and “employability” before these concepts were consistently identified in the data. Some passages of text were assigned dual codes if they represented two concepts (e.g., the roles of judges and expert witnesses).
The properties and dimensions of each category and sub-category were identified. Properties are the “the general or specific characteristics or attributes of a category,” while “dimensions represent the location of a property along a continuum or range” (Strauss & Corbin, 1998, p. 117). Properties of each category and sub-category were expressed as definitions. For example, the properties of metaphors, a sub-category of “the medico-legal system,” were defined as statements representing the medico-legal system as dramatic events such as a sporting competition or military combat, while the dimensions ranged from mild (i.e., “a game”) to moderate (i.e., “a pretty feisty old game”) to severe (i.e., “a war zone”). Participants’ responses were generally unevenly distributed along a continuum, and quotes were selected to show the proportion, intensity and relative placement of the responses (see Chapters 5 to 8).

The transcripts of the first two interviews were initially coded manually to enable the researcher to make annotations in the margins and highlight text relevant to particular research questions. Copies of these transcripts were given to an advisor with extensive qualitative research experience over 15 years (G. C.) so that she could provide independent feedback on the researcher’s tentative open coding. In a collaborative process, feedback on a total of six coded interviews was used to refine the coding categories and develop definitions for each code. Coding categories and sub-categories were drafted and re-drafted on eight separate occasions as newly-identified codes were added and other categories were amalgamated or deleted. The draft of the codes and corresponding definitions (i.e., properties) were given to a second advisor with extensive research experience (J. S.) to use with a coded interview. She gave feedback about clarity of the codes and agreement with the coding of the transcript. This process was used to ensure consistent coding of the textual data by the researcher. All data were coded and analysed.
In the second stage of data analysis, the categories were developed and interconnected with sub-categories in a process known as axial coding (Strauss & Corbin, 1990, 1998). Axial coding involves intense analysis of one category at a time so as to establish the relationship between it and other categories and sub-categories. A guiding principle of axial coding is the identification of any connections and relationships between the categories and sub-categories that influence the main phenomenon. In this research, a connection was made between a category related to occupational therapists’ current expertise in assessment, forming an opinion and writing an expert report and a category in which participants’ recommended strategies for further developing expertise in these areas for the future. Closer examination of text with dual coding indicated a direct relationship between categories. For example, examination of text labelled “barrister” and “psychosocial” revealed a connection between occupational therapists’ reports on psychosocial factors and their experiences of cross-examination by barristers in court.

In the third stage of data analysis, the connections between categories were linked into a comprehensive pattern around a core category in a process known as selective coding (B. Glaser, 1978; Strauss & Corbin, 1998). The core category of research data is the main focus of the participants and the category to which all other categories are readily related during data analysis. The core category occurs frequently and explains variations in the data (Strauss & Corbin, 1998). Although the original title of the research was “The contribution of occupational therapists to medico-legal decision-making about work capacity in the courts,” the researcher realised that participants had all spoken about the occupational therapy expertise in work capacity either as an expert providing a report for the courts or giving expert witness testimony in the courtroom. Through a series of diagrams and analytical comments (i.e., memos), it became apparent that all the textual data could be linked to the abstract concept of
“expertise.” A number of sub-categories (e.g., credibility) of the core category were identified as criteria for occupational therapy expertise. Consequently, during the selective coding stage, “expertise in work capacity” was identified as the core category. That is, the participants identified that the challenge for occupational therapists is to assist the court by providing valued, credible and unbiased expert opinions within their areas of expertise. In addition to this core category, three other categories were identified and related to the core category. A second category included the context in which the expertise is provided (i.e., the medico-legal system including interactions with key stakeholders). A third category included the methods used by occupational therapists to provide their expert opinions. A fourth category included recommendations as to how to develop expertise for the future. The four categories and associated sub-categories, identified during data analysis, are presented accordingly in the results and discussion chapters along with informative quotes from participants (see Chapters 5 to 8).

In the fourth and final stage of data analysis, linkages between the core category and other categories and sub-categories were expressed as a comprehensive series of theoretical formulations in a grounded theory. The theoretical formulations are conceptual and interrelated statements about the principal findings. At first, the grounded theory was tentative and speculative. Through greater levels of conceptualisation and reduction of the data, greater abstraction or levels of “generality” were reached (Strauss & Corbin, 1998, p. 23). The diagram of relationships between the core category and other categories was then developed and examined for how well it represented a wide range of circumstances under which occupational therapists contribute expert opinions on work capacity. Specifically, the researcher reflected on individual transcripts and compared them with the grounded theory. In particular, the researcher sought out disconfirming cases that would indicate a need for modification.
to the grounded theory (Creswell, 1998). The grounded theory was subsequently returned to the participants as “Key Findings” for verification (see section 3.6.2 and Appendix J1-J4 for participant verification package including “Key Findings”).

3.6.1 Data Management

Data collection resulted in approximately 1000 pages of interview data, necessitating an efficient data management system. Data analysis was supported by the use of the QSR NVivo computer software program (Qualitative Solutions and Research Pty. Ltd., 1999). QSR NVivo is one of a number of computer-assisted qualitative data analysis programs that are designed for storage and management of large amounts of textual data (Ezzy, 2002). QSR NVivo is designed as a code-based theory building software program (Weitzman, 2000). The software program enabled the researcher to organise and retrieve data quickly and easily according to key words, phrases, statements or ideas so as to do the following: (a) complete the open coding stage, in which categories and sub-categories were identified; (b) readily examine logical relationships between categories and sub-categories in the axial coding stage; and (c) display selected matrixes of data for inspection, producing reports and theory building. In addition, the software enabled the researcher to develop and refine the properties and dimensions of coding categories and sub-categories, and to record participants’ details as “Attributes” (see Tables 5 and 6 in Chapter 4 for participant details). However, an important distinction needs to be made between the researcher’s essential role in data analysis (i.e., interpretation of the data and theory generation) and a computer program that facilitated the management of data through “sophisticated” indexing and searching systems (Ezzy, 2002, p. 112).
### 3.6.2 Participant Verification of the Grounded Theory

In preparation for the verification of the grounded theory, the participants were contacted by telephone, email or letter to confirm their current addresses, and to emphasise the value of their responses in order to increase the response rate. The researcher was able to contact 30 of the original 31 participants (see Appendix J1). The other participant, a lawyer, could not be contacted. Along with the key findings, participants were sent an explanatory letter, a diagrammatic overview of the key findings, and three questions (see Appendices J2-J5). The participants were asked to comment on their agreement with the key findings or to provide counter-instances from their experiences and perceptions. Twenty participants replied, giving a response rate of 64.5% of all participants. Among the participants who responded were six occupational therapists, three lawyers and four medical specialists who identified themselves by a signature, a comment or a return address. The return of a number of completed responses from each participant group adds to the credibility of the findings. Verifying the key findings was anticipated to take approximately 30 minutes of each participant’s time. However, one medical specialist reported that reviewing the key findings had taken him several hours. Other participants did not comment on the time it had taken them.

All responses from participants were considered. The majority of those who responded indicated agreement with most of the key findings. The participants who agreed with each key finding ranged from 13 (65%) for a key finding about malingering to 20 (100%) for a key finding about occupational therapists’ areas of expertise. Forty out of the 43 key findings gained agreement from 15 or more of the 20 participants. When proposing alterations, the majority of participants requested that individual key findings were further emphasised at a point on the category dimensions, or clarified in the way they suggested. For example, although one participant agreed
that referrals were received 2 to 15 years after injury, she emphasised that it was usually more than 2 years. A medical specialist and occupational therapist who did not undertake all aspects of the identified professional roles wanted these points clarified. Exceptions to the patterns of relationships in the data were used to extend the grounded theory and express it more abstractly, or to incorporate more variations into the theory. All the participants’ comments were incorporated into the results and discussion chapters and/or into Chapter 9, “Identification of a Grounded Theory of Occupational Therapy Expertise in Work Capacity.” In this way an authentic grounded theory that was true to the data collected was developed and would be conceptually transferable to practitioners in a range of situations in the medico-legal specialty. Data analysis ceased after all participant verification responses had been incorporated into the grounded theory.

3.7 Research Rigour

All researchers need to demonstrate that their work can be believed and the extent to which it can be believed and applied in related spheres. “Rigour” is the term used by many qualitative researchers to denote the trustworthiness and usefulness of qualitative research (P. L. Rice & Ezzy, 1999). P. L. Rice and Ezzy proposed a number of strategies or techniques to ensure theoretical, methodological, interpretative, and evaluative rigour. Triangulation and reflexivity are broad strategies that support a number of these types of rigour. A number of strategies have been adopted for this research and are addressed in this section, while strategies for evaluative rigour are addressed under “Ethical Considerations Regarding Participants” (see section 4.5). The strategies used to ensure rigour are also consistent with the guidelines for critical review of qualitative research developed by Law et al. (1998) at McMaster University,

Theoretical rigour includes justification of the research through critical analysis of the research topic, literature and methodology and of the relationship between these facets of the research. These issues are addressed in Part A, “Introduction” in Chapter 1, “Background to the Thesis” and Chapter 2, “Perspectives from the Literature Regarding Occupational Therapy Expert Opinions on Work Capacity.” The soundness of arguments and reasoning, and correct application of concepts have been reviewed by three research advisors, and examined in other peer review processes (see pages iii & iv for presentations and competitive research funding directly related this dissertation). The three research advisors all have extensive clinical, research and medico-legal experience as an occupational therapist (G. C. & J. S.) or clinical neuropsychologist (T. O.) in the areas of work capacity, injury and rehabilitation. G. C. has 15 years experience as a qualitative researcher and advisor (i.e., supervisor). The research advisors provided the researcher with monthly consultation over a 5-year period regarding methodology and research findings, including participant verification of theoretical formulations. Specific consultation processes relevant to the credibility of this research included: (a) advising on the suitability of the methodology relating to the research questions and aims (G. C., & J. S.); (b) independent coding, followed by discussion to reach consensus regarding coding and recoding (G. C.); (c) questioning and critiquing the data interpretation process, including the selection and length of quotes, and the analysis and synthesis of data in the results and discussion chapters (T. O., G. C., & J. S.); (d) during the formulation of the grounded theory, checking that, as the levels of abstraction increased, the individual theoretical formulations of the grounded theory remained consistent with the findings presented in the results and discussion chapters (T. O. & G. C.).
Methodological rigour includes documentation of methodological and analytical process issues and decisions in sufficient detail to enable replication of research including adherence to the researchers’ style. To enhance methodological rigour, participants were all sent their transcripts for editing and removal of identifiers. The description of the research should include the means used to recruit participants, how trust and rapport were developed, how refusals to participate and unexpected events were dealt with, how data were collected and recorded, how data were coded and analysed, and how findings were presented (Altheide & Johnson, 1994, p. 493, cited in P. L. Rice & Ezzy, 1999). These aspects of the research are addressed in detail in Part B, Chapters 3 and 4, “The Research Design and Process.”

Interpretative rigour means that the researcher accurately interprets the participants’ worldview and understanding of events (P. L. Rice & Ezzy, 1999). Pope and Mays (1999) proposed a range of strategies that were adopted in the current research. These strategies included: (a) consultation with experienced researchers about alternative coding of a proportion (approximately one fifth) of the completed transcripts; (b) consideration of alternative explanations and theories to account for data, especially divergent perspectives; and (c) inclusion of sufficient data in the results and discussions chapters (Part C, Chapters 5-8) to adequately support the researcher’s interpretations. A consensus approach to coding and interpretation was used whereby differences between multiple coders were discussed until consensus about coding and interpretation was reached (Patton, 2002). Interpretative rigour was further facilitated through searching for disconfirming evidence of individual experiences and perceptions, and later, of situations in which the provisional grounded theory might not apply (Creswell, 1998). On completion of the interviews and initial data analysis, the grounded theory (labelled “Key Findings”) was verified by participants. Even though data from participant checks themselves require interpretation by the researcher, they
are one of the “strongest available checks on the credibility of a research project”
(Mays & Pope, 1999, p. 4).

With respect to the rigour of the grounded theory specifically, B. Glaser (1978) proposed four criteria that were applied to the findings of the present research. These criteria are: (a) fit, that is, there is compatibility between the categories and the data; (b) workability, that is, the concepts and their sequence are useful explanations of the phenomena under consideration; (c) relevance, that is, the grounded theory offers an analytical explanation of the social problem and social processes; and (d) modifiability, that is, the grounded theory is flexible and durable.

3.7.1 Triangulation

Triangulation of data sources and methods, and consideration of alternative coding and explanations are frequently used to increase the credibility of qualitative research (Mays & Pope, 1999; P. L. Rice & Ezzy, 1999). For this reason, three participant groups were interviewed and three experienced researchers were consulted regarding coding and alternative interpretations of the data. A neuropsychologist with medico-legal experience was included in the advisory team and was able to bring an additional professional perspective and limit the effects of professional biases. Theoretical triangulation occurred when the emerging theory was compared to existing theories of expertise (see Chapter 10).

3.7.2 Reflexivity

In qualitative research the researcher is a research tool (S. Taylor & Bogdan, 1998). As a research tool, the researcher role was to gather, categorise, analyse and interpret data. The researcher accepted responsibility for the interpretative role in the analytic process (Strauss & Corbin, 1994; see also Finlay, 2000), and accounted for her
role in the research. The researcher’s role is considered briefly in section 1.7 and in more detail in the current chapter.

Reflexivity means “sensitivity to the ways in which the researcher and the research process have shaped the data collected, including the role of prior assumptions and experience” (Mays & Pope, 1999, p. 5). The researcher reflected on her actions and the impact they may have had on the research (Hammell & Carpenter, 2004; P. L. Rice & Ezzy, 1999). The researcher made her assumptions about expert opinions on work capacity explicit at the beginning of the study in order to set them aside and allow the substantive theory to emerge (e.g., extract in next paragraph, sections 2.13, and 7.6.1). The researcher was conscious of a researcher’s potential influence on the participants and their responses. Therefore, the researcher was careful to make neutral comments and facial expressions during the interviews, to welcome diversity of socio-political views in the participant sample, and to explore with interest the perspectives and experiences of each participant whom she regarded as an expert. Aspects of the research topic that were of interest to the researcher were included in the Interview Guide. This effect was counteracted by asking participants if they had any other comments that they thought were important to understanding the research topic during individual interviews and, again, during the participant verification of the key findings (see Appendices E, F and J3 for questions).

Rigorous strategies to minimise subjectivity are necessary to ensure credibility of qualitative research. Sherrard (1997) noted the subjective nature of interpretation in qualitative research and the resultant obligation on the researcher “to support, and test, interpretations” (p. 162). Support can be obtained from triangulated methods of data collection and analysis, while testing occurs through seeking counter-instances, considering alternative explanations and checking with participants (Sherrard, 1997). An extract from the researcher’s journal dated April 20, 2000 provides an example of
the researcher recognizing her assumptions and preferences. The extract was as follows: “Biased data and interpretation are of little use to the occupational therapists who undertake medico-legal work capacity assessments. Although my own preference used to be for non-standardised assessments (because of the resource implications, flexibility in rural and remote settings, and ecological validity), my firm belief is that occupational therapists will not only prefer standardised assessments but will avoid non-standardised ones in medico-legal settings.”

3.8 Summary: Methodology and Methods

In this chapter the research design and process used to provide answers to the research questions have been described. The rationale for using a grounded theory methodology and selecting qualitative research methods for this research was explained in detail. The grounded theory methodology was placed within the qualitative research paradigm. In-depth interviews with 31 participants were the primary method used to gather data and were supplemented by field notes and memos. Grounded theory data analysis was informed by Charmaz (2000, 2002), B. Glaser and Strauss (1967), B. Glaser, (1978, 1992), and Strauss and Corbin (1990, 1998). The four stages of systematic data analysis were outlined with supporting examples. The way that the key findings were verified by participants and the responses incorporated to further develop the grounded theory was explained. Strategies used to ensure and judge the credibility of the research were outlined. These strategies were intended to maximise theoretical, methodological, interpretative, and evaluative rigour. In the next chapter (Chapter 4), the details of the research participants and ethical considerations throughout the research will be presented. Chapter 4 will complete Part B, “The Research Design and Process.”
4.0 Introduction

In Chapter 3 aspects of the research design relating to the methodology, methods and means for maintaining rigour in the research were outlined. Chapter 4 will focus on the details of the participants and elaborate on the associated ethical considerations in this research. The chapter will be structured according to (a) theoretical sampling, (b) selection criteria, (c) the recruitment strategy, (d) description of the participant sample, and (e) the ethical considerations regarding participants.

4.1 Theoretical Sampling

Purposeful sampling of participants is typically used in qualitative research to recruit participants with experience of the topic being investigated (Patton, 2002). Grounded theorists use a particular type of purposeful sampling known as theoretical sampling. Founding grounded theorists defined theoretical sampling as selecting participants who can contribute to the development of a theory (B. Glaser & Strauss, 1967; B. Glaser, 1978; Strauss & Corbin, 1990, 1998). More specifically, B. Glaser (1978) described theoretical sampling as “the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides which data to collect next [from whom] and where to find [data], in order to develop his theory as it emerges” (p. 36). In this research, participant selection progressed systematically from those participants who were initially purposefully selected as
having experience of the topic being investigated, to those who could further contribute to the theory development as categories emerged and the research became more focussed. Although the three participating professional groups were identified before commencement of the research, the numbers and specialty experiences of the sample were not predetermined.

4.2 Selection Criteria

Basic social processes for occupational therapists in the medico-legal system are written and oral communication with members of the legal professions. Other medico-legal social processes occur when medical specialists’ and occupational therapists’ reports are exchanged via a solicitor for perusal and comment, and on those occasions when medical specialists recommend that solicitors refer to occupational therapists. Therefore, members of these three professional groups with experience of the research topic were considered well placed to assist the researcher to answer the research questions by providing their views and insights. Consequently, participants were initially selected for inclusion in the research according to each of the following criteria. The person:

(a) Is a member of the occupational therapy, legal, or medical professions;

(b) Has direct experience of occupational therapy medico-legal work capacity reports in the previous three years; and

(c) Is available for a 1-hour interview in person or by telephone within the timeframe and cost resources available for the research.

4.3 The Recruitment Strategy

Guided by theoretical sampling principles, occupational therapists, and members of the legal and medical professions with particular experience and expertise
were progressively sought. Potential participants were initially contacted either via their secretaries, or directly by telephone or email, and invited to participate in the research. If the prospective participant expressed interest, he/she was asked to read and sign the Participant Information Sheet (see Appendix B) and Informed Consent Form (see Appendix C) that were faxed or mailed. Employees who would be discussing their experiences while working in an organisation were also requested to obtain the approval of the relevant authority in the form of a signature on a Gatekeeper Letter (see Appendix D). Once contact was made, subsequent contact included paper mail or electronic mail, depending on the preference of the prospective participant.

Initially, three occupational therapists were selected because they were identified by the researcher as occupational therapists who practiced in Queensland, and were known to have given evidence on work capacity to a Supreme Court, District Court, or Human Rights and Equal Opportunity Commission in the previous 3 years. The first six interviews were undertaken with occupational therapists. Thereafter, interviews with occupational therapists were interspersed with interviews with the legal and medical specialists. As the research progressed, the researcher identified some categories and sub-categories in the data, and further interview data were sought to saturate them. One of these categories consisted of occupational therapists who specialised in a specific disability or assessment (e.g., TBI).

Soon after commencing data collection the researcher’s understanding of occupational therapists’ contribution to medico-legal decisions was expanded to include those who had written reports for insurers, the courts and quasi-judicial courts but who had not attended a trial or tribunal as an expert witness. Sampling was adjusted accordingly. The sample of 19 occupational therapists included nine who identified that they provided reports predominantly for either plaintiff or defendant lawyers, and six who identified that they worked for both plaintiff and defendant lawyers. The sample
included five occupational therapists who specialised in a specific disability (e.g., spinal cord injury) or a specific assessment (e.g., motor vehicle driving) along with fourteen occupational therapists who were selected because they assessed the work capacity of a range of client groups. The selection of occupational therapists from metropolitan and non-metropolitan regions of Queensland was complemented by the selection of a smaller number of occupational therapists with interstate and/or overseas experience (see Table 6). This was an attempt to gain maximum variation in the sample and determine the extent to which the findings applied under different circumstances and in different geographical locations. The extent to which this occurred was limited by resource constraints.

Legal practitioners and medical specialists were also recruited through theoretical sampling. The selection of lawyers included those practicing personal injury litigation and who represented either plaintiffs or defendants in court. Theoretical sampling resulted in the inclusion of a judge and a plaintiff barrister in the sample as well as four solicitors. Three of the solicitors acted for the defendant, one of whom was employed by a motor accident insurer.

The specialist medical practitioners had a range of qualifications and experiences of injury prevention, rehabilitation and compensation. Orthopaedic surgeons and occupational physicians were included in the sample. While no specialist medical practitioner identified that he worked mainly for the plaintiff, one orthopaedic surgeon identified that he worked mainly for the defendant.

Patton (2002) stated that “rigor and integrity” are needed on the part of the researcher “in looking for and sampling confirming as well as disconfirming cases” (p. 239). Therefore, competing and contradictory views were considered necessary in order to develop a theory that would apply in more unusual situations as well as the most
frequently encountered ones. The rigour of the participant recruitment was further increased by using combinations of the following methods:

1. Personal knowledge: The researcher knew of some participants’ involvement in the medico-legal field through mutual professional activities over the past two decades.

2. Inquiry: During an interview the researcher asked a participant to identify other potential participants with either a similar or different perspective or experience. Alternatively, a participant or key informant spontaneously described a colleague in these ways.

3. Professional activity: The participant had been professionally active by having publications in peer-reviewed journals or books, or making presentations at professional seminars and conferences on medico-legal topics.

4. Legal document: The participant was identified from a published legal document.

5. Professional list: The participant was identified from a professional list on a website or on marketing material for their organisation.

A list of occupational therapists in medico-legal practice in Queensland and their contact details was available through the professional association, Occupational Therapy Australia - Queensland, especially its six monthly publications “Who’s Working Where.” Some sources provided information about both medical specialists and legal practitioners. Through the Queensland Law Society contact was made with the Medico-Legal Association of Queensland and, through them, with a member of their executive committee who listed several members and their contacts. Several participants had previously been or were currently office holders in a relevant professional organisation. An occupational physicians’ website was also accessed.
The details of the recruitment methods employed are summarised according to the three participant groups, namely, occupational therapists (OT), members of the legal professions (L), and medical specialists (M) (see Table 4).

Table 4
Details of Recruitment Methods Employed for Each Participant Group

<table>
<thead>
<tr>
<th>Recruitment methods</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>One method</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Two methods</td>
<td>12</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Three methods</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Four methods</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

In addition to being selected on the basis of theoretical sampling, Table 4 demonstrates that two methods were used to identify and recruit the majority of participants in each profession group. All four participants who were recruited by one method only were identified by researcher inquiry to other participants or key informants (see section 3.5.3 for further information on key informants).

4.4 Description of the Participant Sample

The sample totalled 31 participants, of whom 19 were occupational therapists, 6 were medical specialists and 6 were members of the legal professions. A sample of 20 to 30 participants is usual for grounded theory (Creswell, 1998). The sample size for
the current research is similar to the larger samples in occupational therapy studies using grounded theory (Stanley & Cheek, 2003).

Nineteen out of 24 occupational therapists who were invited, agreed to participate. Of those who declined, two occupational therapists stated they had never been involved in a medico-legal practice, and one agreed to participate but did not keep the first appointment and did not reply to requests for a second appointment. Another occupational therapist was given the relevant information and an invitation to participate but did not respond after returning from a holiday, and one declined due to other commitments. The response rate for medical specialists was six out of the seven who were invited to participate. One recommended medical specialist did not respond to two telephone requests and information faxed to his practice and, therefore, was not contacted again. As saturation of the major categories of data had occurred recruitment of medical specialists ceased. The response rate for lawyers was six out of nine. Reasons given for not wanting to participate were that one potential participant was no longer involved in personal injury cases, and that one potential participant’s employer had concerns about the legal practice being identified in spite of confidentiality assurances. One barrister who responded to an initial request did not respond to a second telephone call after information was faxed to his practice, and was not re-contacted.

Details of the three groups of participants and their medico-legal practices were recorded (see Table 5 and Table 6). The details were collected either at the commencement of each interview on the Pro forma for Part 1 of In-depth Interviews (see Appendix G) or otherwise recorded after each interview in NVivo as Attributes (Qualitative Solutions and Research, 1999).

With reference to Table 5, the age ranges indicated that the occupational therapy participant group included younger participants. The modal age decade for each
group suggested that the medical specialists were older than both the lawyers and occupational therapists. This is consistent with the years of medico-legal experience reported by each professional group (see Table 5).

Table 5
Summary of Participants’ Demographic and Employment Characteristics

<table>
<thead>
<tr>
<th>Details of 31 participants</th>
<th>OT (n=19)</th>
<th>L (n=6)</th>
<th>M (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at interview</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range in years</td>
<td>20-69</td>
<td>30-75</td>
<td>40-69</td>
</tr>
<tr>
<td>Years (modal decade)</td>
<td>30-39</td>
<td>30-39</td>
<td>50-59</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Employment category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>17</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Part-time</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Employment sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private sector as:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- sole or principal</td>
<td>13</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>- employee</td>
<td>3</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Public sector employee</td>
<td>3</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>
The sample included more female than male occupational therapists and more male than female medical specialists and lawyers, reflecting the composition of each profession. Approximately 90% of the members of the occupational therapy profession are female (AIHW, 1998). Of the 31 participants all but three were in full-time employment. The majority of participants were employed in the private sector, principally as sole practitioners or as principals in a group practice.

With reference to Table 6, the majority of participants identified that they had all relevant medico-legal experience or expertise listed for her/his profession (see Appendix G for pro forma). In the case of occupational therapists, the relevant experience and expertise included: (a) recommending, providing and perusing other occupational therapy reports; (b) providing an expert opinion regarding work capacity; (c) knowledge of the relevant medico-legal processes; and (d) knowledge of relevant work-related legislation. All occupational therapists had provided and/or perused medico-legal work capacity reports, however, a number had not attended trial as an expert witness. Lawyers and medical specialists had requested or recommended, rather than provided, occupational therapy reports and expert opinions regarding work capacity. Participants were principally residents of Queensland, although eight occupational therapists and two medical specialists currently practiced or had practiced interstate or overseas. A comparison of the number of participants (n=31) and the total number of geographical areas of practice (n=51) indicated that participants typically provide services in more than one geographical area. From the documentation of the years of medico-legal experience, the more restricted experience of occupational therapists compared to the other participant groups was evident. A small number of participants indicated that they no longer undertook medico-legal work in their current employment and the interview was based on their recent past experiences.
Table 6
Details of Participants’ Medico-legal Practices

<table>
<thead>
<tr>
<th>Medico-legal practices</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of medico-legal experiencesa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All experiences listed for profession</td>
<td>10</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>All experiences except recommend OT to lawyer</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>All experiences except one or two of following:</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Knowledge of medico-legal proceedings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Knowledge of legislation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Experience as expert witness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographical areas of medico-legal practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brisbane</td>
<td>14</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Queensland – other</td>
<td>7</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Other Australian state</td>
<td>6</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>International</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Medico-legal experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range in years</td>
<td>1-20</td>
<td>7-28</td>
<td>7-30</td>
</tr>
<tr>
<td>Mean in years</td>
<td>8.2</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Currently active in a medico-legal practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>No (but within the last 3 years)</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*aRefer to Appendix G for relevant details.*
4.5 Ethical Considerations Regarding Participants

This research was conducted according to published guidelines for the conduct of ethical research involving humans (National Health and Medical Research Council [NHMRC], 1999). Initial Ethical Approval for the research was gained from the Behavioural and Social Sciences Ethical Review Committee (BSSERC) at The University of Queensland on October 11, 2000. Amended applications and relevant ethical clearance statements were approved by BSSERC on August 10, 2001 and December 16, 2004. The first amended application for ethical approval was required before employees of insurers and public sector organisations could be recruited as participants with their employer’s (i.e., gatekeeper) consent (see Appendix D). The second amendment extended the time available to receive participant verification of the key findings (see Appendices J1-J5). Ethical considerations have been applied in the following ways to the conduct of the research.

1. The confidentiality of participants, their clients and employers has been respected. Participants each selected or were given a pseudonym, and their locations and specific occupations have been disguised. Transcripts were returned to participants for correction and removal of remaining identifiers. Information that revealed the identity of participants was removed between the data collection and data analysis stage. At that stage each participant was assigned an alpha-numeric code to represent their profession, that is, OT1-OT19 represents occupational therapists, M1-M6 represents medical specialists, and L1-L6 represents members of the legal professions (see Appendix I for a list of participants’ pseudonyms according to their professions). Individualised data were not presented in tables of participant details (see Tables 5 and 6).
2. The participants’ privacy has been safeguarded. Privacy was maintained at the data collection stage by ensuring that interviews were arranged and conducted privately with participants. The privacy of individuals and employing organisations has been maintained through focussing the research on the aggregated results, an abstract theory and objective implications for the occupational therapy profession.

3. The risks of harm and discomfort for participants were estimated to be minimal because of the nature of the research and because the interviews were undertaken with autonomous and experienced members of occupational therapy, legal and medical professions. Interview times and venues were scheduled to minimise inconvenience to participants during their working day. Participants were invited to stop the audio-taped recording of the interview as required. Consideration was given to the structure and formatting of the key findings and associated questions so as to minimise the time needed by participants to verify them.

4. All participants were informed of the nature of the research, its purpose, the intention to audio-tape and transcribe the interviews, and the plan to use the synthesised findings to improve occupational therapy medico-legal contribution (e.g., through publications and/or presentations) before they were asked to sign an Informed Consent Form.

5. For those participants who were employed by a public or private sector organisation, a signed gatekeeper letter was obtained prior to interview. This ensured that the permission of an authoritative person such as a section manager or line supervisor was given before participation.

6. Participation was voluntary for the length of the research. All participants were free to decline participation and were able to withdraw from the
research at any stage without removing their rights and the researcher’s responsibilities.

7. Data have been held in a secure place by the researcher. Participant data and audio-taped interview data will continue to be held in lockable cabinets by the researcher for 5 years from completion of the research. Electronic data will be held by the researcher for 5 years from publication in password-protected files. Data will be erased at the end of this holding period.

8. The researcher is committed to presenting important findings to participants and to the occupational therapy profession. Some findings were made available to the occupational therapy participants through a paper presented at a national Occupational Therapy conference in 2003 after interviews were completed. A summary of the conference presentation, based on the experiences of the occupational therapist participants, was sent to occupational therapy participants. Some findings were also presented to occupational therapists at the Work Special Interest Group of Occupational Therapy Australia - Queensland in 2004, and to health and rehabilitation professionals at the School of Health and Rehabilitation Sciences Post-graduate Research Seminars in 2003 and 2005. Participants were informed of the key findings. Three publications in peer-reviewed journals are planned. A research grant from the Occupational Therapy Board of Queensland has facilitated the writing of the first of these publications (see p. iii).

9. The researcher’s employment obligations were compatible with the aims of the research. No conflicts of interest were envisaged as there is no financial gain to be made from the research.
Following the return of the transcripts to each individual, two participants requested that they be further disguised to protect their anonymity. Changes were made and the transcript returned in one instance. In another response, the participant was reassured that the whole transcript would not be placed in the thesis and that the researcher had a continuing responsibility to protect the identity of all participants. The participant was satisfied with these guarantees. Participants were also reassured that anonymity would be further protected by the inclusion in the study of practitioners located throughout the state, from interstate and overseas. Unexpectedly, a number of the legal and medical specialists expressed surprise at being given a pseudonym and, on occasions, said they would like to have their name associated with the views they expressed. The researcher explained that this could lead to unforeseen problems and that anonymity would be maintained (S. Taylor & Bogdan, 1998).

4.6 Summary: The Participants

This chapter, Part B Chapter 4, contained a description of the 31 participants from whom data were obtained for this research, and a commitment to the research being conducted ethically. The research participants included 19 occupational therapists, 6 medical specialists and 6 lawyers. Although the majority of participants were based in Queensland, a substantial minority had interstate or overseas medico-legal practice experience. The sample meets recommendations for sample size and diversity in grounded theory research and recruitment using theoretical sampling. The research was conducted according to the ethical principles recommended by the NHMRC (1999).

Chapter 4 concludes Part B. Part C consists of four chapters (Chapters 5 – 8) in which the research data that were provided by the participants will be presented and interpreted.
PART C: RESULTS AND DISCUSSION

CHAPTER 5

UNDERSTANDING THE MEDICO-LEGAL SYSTEM AND OCCUPATIONAL THERAPISTS’ INTERACTIONS WITH STAKEHOLDERS

5.0 Introduction

In Part C, the data from the participants will be presented, discussed and interpreted in four chapters. The four chapters will focus on aspects of occupational therapy contribution to work capacity decisions in the courts. These aspects will be considered in the following chapters: (a) understanding the medico-legal system and occupational therapy interactions with stakeholders; (b) identifying occupational therapy areas of expertise that assist the courts; (c) occupational therapists’ methods of assessing, forming opinions and writing reports on work capacity; and (d) systematically improving occupational therapy expert opinions on work capacity. In each of these four chapters, representative quotes will illustrate the range of participants’ experiences and perspectives. A small number of quotes from the participant verification of key findings will be included to clarify, extend or qualify the interview data.

Findings will generally be presented according to the following sequence: occupational therapists (OT), lawyers (L) and medical specialists (M). The use of the abbreviations (OT, L or M) with a pseudonym will indicate an individual participant and his/her profession. A summary and discussion will follow each section in the four chapters, which is consistent with qualitative research approaches (Patton, 2002). The
conclusion of each chapter will be expressed initially as key findings (see Appendix J5), and then, following the participant verification phase, as the individual theoretical formulations of the grounded theory (see Chapter 9, “Identification of a Grounded Theory of Occupational Therapy Expertise in Work Capacity”).

The first of the four results and discussion chapters, Chapter 5, will be presented in two sections. In the first section, occupational therapy expert opinions on work capacity will be related to the medico-legal system. In the second section, the roles of stakeholders and their relationships with occupational therapists will be examined.

**Relating Occupational Therapy Expert Opinions on Work Capacity to the Medico-Legal System**

This section will be structured according to (a) relevant medico-legal concepts and processes, (b) laws and jurisdictions, (c) metaphors for the medico-legal system, (d) medico-legal work capacity opinions and return-to-work rehabilitation, and (e) medico-legal assessments for gratuitous care and assistance claims and their relationship to medico-legal work capacity opinions.

**5.1 Medico-legal Concepts and Processes Related to Opinions on Work Capacity**

Participants related occupational therapy expert opinions on work capacity to relevant medico-legal concepts and processes. Two lawyers outlined the legal basis of common law claims. Both lawyers emphasised that the principle of compensation claims in common law is restitution for losses incurred.
Martin: ... a compensation claim fundamentally is only available to a victim who has been injured through the tortious conduct of another, [that is,] through the wrongful action, negligent action or inaction of another. And the fundamental premise of the law is to provide complete restitution to return the person to the position they would have been in but for the accident. A court assesses the claim and because we can’t restore the person’s health, the next best thing that we can do is to try to measure, in monetary terms, the loss suffered. ... So we look at various heads of damages, [such as] general damages, special damages, past economic loss, future economic loss, and care that might be provided. Economic loss, both past economic loss and future economic loss, is a big-ticket item. And there is a lot of litigation over a person’s occupational capacity.

Further, Sean stated, “All of those personal injury cases where people are making claims based on injury sustained, the major component of damages people receive is damages for economic loss - loss of earnings.” Martin explained that if an injured worker retrains after the injury, and earns more then beforehand, there is no basis for compensation for economic loss. However he said, “That’s often, of course, not the case.”

5.1.1 Issues for Occupational Therapists in the Medico-legal System

Occupational therapy and legal participants identified the determination of quantum, the experience of working in an adversarial context, and, to a lesser extent, being reasonable, as issues for occupational therapists in the medico-legal system.

Participants identified that in common law the aim of the courts is to determine liability and quantum. Occupational therapists assist mainly in the determination of
quantum, particularly the financial compensation for economic loss, including future
economic loss. Jan (OT) and Ona (OT) confirmed that for the quantum of a common
law case, loss of employment and the potential to be employed are important
considerations. Jan related occupational therapy opinions to these issues of quantum
and employment, and emphasised the need to change the focus of occupational therapy
reports to these issues rather than preparing reports for rehabilitation purposes.

Jan: The court isn’t so much interested in what the person does or how. They’re
interested in this thing that is lost, because the whole aim of the court is to
award compensation and so they need to know if there’s been a loss. So your
work should support a determining of whether there has been a loss, and you
need to quantify it so the court can then put an economic value on it.

Ona: They not only want to know the person’s ability to undertake their
previous employment. ... [Some] aren’t in employment at all and the plaintiff’s
barrister is trying to argue that they can never work again. So, obviously it is
going to reduce the claim significantly if they even work in any employment for
the next 30 years.

In some cases involving occupational therapists, the quantum can be extensive.
Participants reported settlements of up to $15,000,000 for severe injury cases with
which they were involved, while figures of approximately $100,000 are common in
chronic low back pain cases. Stan (OT) said occupational therapists need to write
personal injury reports carefully because, “if there is money involved with anything, -
and there’s lots of money involved with some of this stuff - remember that people are
not likely, when it comes to the crunch, to cut you any slack.”
Some participants emphasised that personal injury litigation is an “adversarial” process. John (OT) said that means it is “an antagonistic process between defendant and claimant.” Martin (L) stated that the conflict is between competing sides about “whether or not the person can return to the job, do the same job or do a different job.” Occupational therapists’ reports on work capacity might be used to support one party (Sue, OT; Ona, OT). Of an occupational therapy report, Maree (OT) said “one party is going to challenge that document: one party wants it to be better or worse.”

Nine occupational therapists indicated that they work predominantly, but not necessarily exclusively, for either the plaintiff or the defendant. Four occupational therapists did not specify the proportion of referrals they received from either side. The remaining six occupational therapists stated that they work for, and prefer to work for, both sides. However, at times, they may be engaged by the side they would prefer not to represent. Occupational therapists identified patterns that they associated with reporting for the plaintiff/claimant or defendant (see Table 7). [Note: The terms “claimant” and “plaintiff” were used almost synonymously and will be used according to the term chosen by each participant].

Receiving and accepting referrals from both plaintiff and defendant lawyers was perceived as an indicator of an expert’s neutrality. Sophie (OT) said, “Sometimes when health professionals act on one side only, their opinion ends up a bit skewed, it’s not even.” Early in his medico-legal experience, one occupational therapist, Alex, said he believed that he needed to give a certain perspective “because I was acting with the plaintiff.” He later sought guidance from his profession on this ethical issue.
Table 7

Patterns that Occupational Therapists Associated with Reporting for the Plaintiff or Defendant

<table>
<thead>
<tr>
<th>Reporting for the Plaintiff</th>
<th>Reporting for the Defendant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Starting out in the medico-legal field</td>
<td>1. Having increased skills and experience</td>
</tr>
<tr>
<td>2. Giving the primary opinion</td>
<td>2. Giving an opinion of a colleague’s report</td>
</tr>
<tr>
<td>3. Accepting referrals from a major source</td>
<td>3. Working for a larger rehabilitation provider</td>
</tr>
<tr>
<td>4. Tending to increase compensation</td>
<td>4. Tending to decrease compensation</td>
</tr>
<tr>
<td>5. Undertaking an assessment</td>
<td>5. Not necessarily undertaking an assessment</td>
</tr>
</tbody>
</table>

With respect to the potential influence of the referrer, Martin, a plaintiff lawyer, said plaintiffs need to trust that the assessing occupational therapist is independent of the insurer and employer rather than rushing them back to work. Martin said that plaintiffs “might be a bit sceptical about whether the OT is acting in the best interests of the [plaintiff], in their [own] self-interest, or in the interest of who’s paying the bills.” Given the potential for opinions to be perceived as biased, five occupational therapists emphasised the importance of occupational therapists remaining neutral and writing expert reports that are accepted by both the plaintiff and defendant parties.

Some problems were associated with giving a second opinion for the defendant. Six occupational therapists referred to reviewing their colleagues’ reports, and some were aware of the potential for bias and conflict with members of their profession. Sophie (OT) said, “You’re always looking for the fault, for what’s wrong, rather than looking at it objectively.” A second opinion might include consultation about items in the statement of damages (e.g., recommended training to increase a person’s
employability), and what questions should be asked in court. Jessie (OT) cautioned occupational therapists, “There cannot be an assumption that the cross-examiner doesn’t know what you’re talking about ... because, they’ll have someone like me briefing them.” However, Paogong (L) said, “If the one [occupational therapy report] for the plaintiff is satisfactory and reasonable, the defence might not bother to get one.”

The medico-legal concept “reasonable” was used by four occupational therapists. The inclusion of costly recommendations such as heated swimming pools can be problematic in some occupational therapists’ reports. On the other hand, some reasonable aids and equipment may be omitted from some primary occupational therapy reports. Antionette (OT) said being reasonable meant being a “little bit more on the conservative side as opposed to the over-generous.” She checked herself by imagining the judge exclaiming, “Oh, you’ve got to be joking!” if her recommendations were excessive. However, Ona (OT) found that being reasonable is only one consideration for lawyers once a matter has gone to trial. She said either side might then try to go beyond what she considered reasonable “for as much as they could get.”

5.1.2 Timing of Requests for Occupational Therapy Expert Opinions

Occupational therapists and medical specialists gave a number of indicators for the timing of referrals for medico-legal opinions. A principal indicator is the time at which a person’s condition is considered “stable and stationary,” a concept meaning that medical opinion is that no other medical treatment will result in further improvements. Two occupational therapists said that before this stage it is difficult to determine the person’s residual function. Owen (M) stated that occupational therapists’ opinions are sought “when the trouble has come, when the storm has brewed,” that is,
when there is a dispute that could not easily be resolved through negotiation and mediation. Participants identified other stages at which claimants are referred to occupational therapists. These include when (a) the claimant has completed vocational rehabilitation and has returned to work, (b) the claimant’s medical condition is sufficiently stable for employment to be considered, (c) the insurer believes the claimant is waiting for the claim to settle before returning to work, and (d) a trial or a settlement conference is imminent. Referrals are usually made approximately 2 years after an injury, but on rare occasions occupational therapists reported receiving them as early as 2 weeks and as late as 15 years after the injury.

5.2 Laws and Jurisdictions Relevant to Occupational Therapy Opinions

Participant groups identified a number of different areas of common and statutory law under which personal injury claims for compensation for loss of earning capacity are considered, and which are applied in courts and tribunals. The areas of law include the common law provisions of workers’ compensation, motor vehicle accidents, medical malpractice, public liability, and superannuation disability. They also include the statutory provisions of government administration and anti-discrimination legislation. In addition, on occasions, occupational therapists reported assessing the work capacity of victims of crimes for hearings in a compensation tribunal. Participants identified a number of jurisdictions in which they encounter occupational therapists’ work capacity opinions (see Table 8). Supreme Courts and District Courts are the jurisdictions in which occupational therapists most frequently appear as expert witnesses on work capacity. Three occupational therapists experienced some differences between these two jurisdictions (see Table 9). Jan said that compared to these higher and intermediate courts, the lower quasi-judicial courts are less formal in their proceedings, such as, in the examination of expert witnesses.
<table>
<thead>
<tr>
<th>Jurisdictions Utilising Occupational Therapists’ Work-Related Opinions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdictions according to level of government</td>
</tr>
<tr>
<td>State Supreme Courts - Court of Appeal</td>
</tr>
<tr>
<td>State Supreme Courts</td>
</tr>
<tr>
<td>State District Courts/County Court in Victoria</td>
</tr>
<tr>
<td>Federal and State Industrial Relations Commissions</td>
</tr>
<tr>
<td>State or Local Magistrates Courts</td>
</tr>
<tr>
<td>Federal and State Administrative Appeals Tribunals</td>
</tr>
<tr>
<td>Federal Tribunals (e.g., Social Security Tribunals, Human Rights and Equal Opportunity Commission)</td>
</tr>
<tr>
<td>State Tribunals (e.g., Anti-discrimination, Crimes Compensation)</td>
</tr>
</tbody>
</table>

Occupational therapists and lawyers estimated that between 1% and 10% of court actions proceed to trial, with figures of less than 5% most commonly indicated. The reasons given for court actions going to trial include (a) unresolved issues of liability, (b) disputes between lawyers about "big ticket items" of quantum such as economic loss, (c) the personalities of some lawyers, and (d) the high expectations of some claimants. The costs of litigation account for fewer occupational therapy work capacity reports in anti-discrimination cases. Martin said, "[An occupational therapist’s report] might cost them $5000 - not too many unions would be able to do that."
Table 9
Experiences of Occupational Therapists in Queensland Supreme and District Courts

<table>
<thead>
<tr>
<th>Supreme Courts</th>
<th>District Courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Matters worth $250,000 or more</td>
<td>1. Matters from $50,000 - $250,000</td>
</tr>
<tr>
<td>2. Both sides have occupational therapy opinions</td>
<td>2. A barrister may handle the case</td>
</tr>
<tr>
<td>3. Barristers are briefed on questions by a second OT</td>
<td>3. More junior counsel is involved</td>
</tr>
<tr>
<td>4. Barristers know what an OT is, and know basic</td>
<td>4. Barristers may understand a little</td>
</tr>
<tr>
<td>concepts of occupational rehabilitation</td>
<td>about orthopaedics but not OT</td>
</tr>
<tr>
<td>5. A larger number and more senior lawyers&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5. The referring solicitor may be absent</td>
</tr>
<tr>
<td>6. More rigorous (e.g., Donald: “plenty of notes and plenty of information to</td>
<td>6. Some novice junior counsel who lack confidence</td>
</tr>
<tr>
<td>put you on the spot”)</td>
<td>are involved</td>
</tr>
</tbody>
</table>

<sup>a</sup>The lawyers specifically referred to as being present were Queen’s Counsel (QC) or Senior Counsel (SC), junior and senior counsel, 2 to 3 solicitors, and an articled clerk.

Participants confirmed that differences between Australian states might impact on occupational therapists. Jessie (OT) said, “Even though common law, tort law, is a Commonwealth law, it’s different in each state.” In particular, Jessie said that acceptance of some recommendations might vary, according to precedents set in each jurisdiction. Access to fault-based common law provisions of workers’ compensation acts also varies from state to state, and is subject to changes in legislation (see sections 8.1-8.3 for further details on trends impacting on occupational therapy work capacity opinions). Iamra (M) described the context of most workers’ compensation and rehabilitation as “not a legal process, I mean there’s a legal basis to it, but it’s not determined by courts.” This reference emphasised that the majority of workers’
compensation claims do not proceed to common law in Queensland, and that rehabilitation and medico-legal systems overlap.

5.3 Metaphors for the Medico-legal System

Six occupational therapists, two lawyers and one medical specialist characterised aspects of the medico-legal system metaphorically in terms of a game or battle. Occupational therapists described it as “a game” played by plaintiff and defendant sides (Alex, John), “a serious game” (Madonna), “a bigger game outside your control” (Jennifer), or “a pretty feisty old game” (Stan). Donald (OT) described the court as “a war zone,” in which the sides “come armed” with reports, and sometimes they “hate each other,” and “have to win ... some sort of moral victory.” Two lawyers described the medico-legal system as a “tug-of-war” (Martin), and as “fighting” (Scully). Interestingly, medical specialist, Matthew, aims to make his opinions “bullet-proof,” so he will not “get ambushed in court.”

5.4 Rehabilitation and Medico-legal Work Capacity Assessments

Three occupational therapists and four lawyers identified the relationship between the larger volume of rehabilitation referrals, especially under compulsory workers’ compensation legislation, and the smaller volume of medico-legal referrals, some of which arise from compulsory third party insurance (CTP) (see Table 10). From Table 10 it can be seen that both lawyers and occupational therapists consider that rehabilitation should be completed before any legal proceedings commence. Yet, one solicitor said that plaintiff lawyers are perceived as not favouring rehabilitation in the same way as the medical profession (in which he included occupational therapists).
Martin: The medical profession ... is interested in returning the person, restoring that person to health, as quickly as possible and they see the lawyer as stymieing the person’s recovery, by trying to have the person maximise the claim.

Table 10

Comparison of Medico-Legal Assessments and Rehabilitation

1. Occupational therapists’ perspectives were that medico-legal assessments:

   are generally undertaken by “independent” not “treating” occupational therapists;
   reduce rehabilitation effectiveness if conducted too early (e.g., < 2 years post injury);
   are of secondary importance to return-to-work rehabilitation in the CTP insurance context;
   are often focussed on what a person cannot do, and less on what the person can do;
   should identify the need for further rehabilitation; and
   are more important than plaintiffs’ attempts to mitigate losses, once in court.

2. Lawyers’ perspectives were that rehabilitation:

   means injured workers are returned to paid employment;
   means workers avoid “the social security or health system merry-go-round” (Martin)
   means economic savings for employers whose insurance premiums do not rise;
   means economic savings for insurers who pay the compensation;
   reduces employers’ exposure to liability and litigation costs for future economic loss;
   should be completed before litigation commences, or it could be less effective; and
   could not overcome the lack of employers willing to employ many clients with injuries.

Medical specialists and lawyers consistently acknowledged that occupational therapists provide rehabilitation services as well as medico-legal assessments for injured workers. Edmond (M) said, “They are naturals in rehabilitation.” He had seen
many occupational therapy rehabilitation reports and said, “They’re very good and I find them very precise, accurate and middle of the road [unbiased].” Sean (L) praised organisations with occupational therapists that offer both “rehab and expert legal services.” Two other lawyers commended occupational therapists for the savings they make by returning people to work. Max (L) highlighted the large economic loss payable by insurers of young employees in the mining industry who do not return to work. He said, “Multiply their $80,000 - $100,000 a year or whatever they’ve made, by 30 years.” In contrast, one lawyer pointed out a limitation of return-to-work rehabilitation programs. Jill (L) said if a person has a “bad back … and they re-injure their back at work, that employer is then stuck with the workers’ comp claim and their premiums go up … it’s very hard for these people to actually get a job.”

Several occupational therapists have a balance between medico-legal and rehabilitation practices that suited them, based on work satisfaction, years of experience and the number of experienced staff they could recruit. The proportion of medico-legal specialty work within individual practices varies from less than 10% to more than 50%. Four participants strongly supported the need for occupational therapists to combine a medico-legal practice with a rehabilitation practice in order to maintain credibility in the courts. Ona said work rehabilitation experience is needed “so they do have greater experience of the reality of obtaining and seeking employment after injury.”

5.5 Assessments for Gratuitous Care and Assistance Claims

Assessments of ADL for gratuitous care and assistance claims are the basis of some occupational therapy personal injury assessments. Stan (OT) stated that occupational therapists provide “a unique service in terms of a person’s ability to function, to engage in daily function, whether it is self-care or [household] chores or recreation, work or education.” Martin (L) said that a care and assistance claim is a
“big ticket item,” like economic loss from loss of work capacity. Similarly, Madonna (OT) said it is the other “really powerful area” of occupational therapy contribution in cases of moderate disability. She stated, “[Lawyers say] ‘You’ve got to have an OT say it, to get that in the compensation pay-out.’” ADL assessments that identify loss of functional capacity and, consequently, the gratuitous care and assistance provided by family and friends for extended periods of time form the basis of Griffiths v. Kerkemeyer (1977) claims. As ADL and gratuitous care and assistance claims are peripheral to the present research, participants’ views on it were not explored further.

5.6 Summary and Discussion: Occupational Therapy in the Medico-legal System

Issues associated with the medico-legal system in which occupational therapists provide work capacity opinions were identified predominantly by occupational therapists and lawyers. Medico-legal issues for occupational therapists in common law cases are: (a) estimating loss of work capacity due to injury so that the quantum of economic loss, including future economic loss, can be calculated by the courts; (b) working in an adversarial system, where experts’ reports are frequently challenged; (c) remaining neutral whether working as experts for the plaintiff or defendant; and (d) making reasonable recommendations. Participants identified that referrals are commonly made 2 or more years after an injury when the claimant’s condition has stabilised and when occupational therapists can more accurately assess residual work capacity. An increasing number of Australian federal and state jurisdictions, principally Supreme and District or County Courts, rely on occupational therapy expert opinions. Their opinions are also used in tribunals and commissions. An estimated 90-95% of cases do not proceed to trial. Laws and jurisdictions and changes to these can effect
occupational therapists’ contribution to decisions on work capacity. Medico-legal occupational therapists need to write reports with care because of the financial implications. They need to be prepared to attend court when the quantum of economic loss due to loss of work capacity is the issue to be determined. In comparison to some earlier literature that emphasised the role of occupational therapists as expert witnesses in court (deMaio-Feldman, 1987; Shriver, 1989), this finding strongly suggests that equal emphasis needs to be given to training occupational therapists as experts in medico-legal report-writing and as expert witnesses in the court.

Metaphors are powerful linguistic tools providing insights into the predominant features of a situation (Mohan et al., 1997). The participants’ metaphors for the medico-legal system are sporting competitions and battles. Similar metaphors have previously been used in the literature by psychologists and medical practitioners, especially for the courtroom (Blau, 1998; Breen et al., 1997; Brodsky, 1991). Congruent with these metaphors for the medico-legal system are references to the medico-legal experts as “duelling” (Arup, 1998) or as “hired guns” (Barrister, 1999; Saks, 1990). Unlike previous accounts, participants in the present research did not use metaphors or similes such as a painting, a play or a film for a legal case (Freckelton & Selby, 2002), or liken the courtroom to a theatrical event (Brodsky, 1991). The implications are that occupational therapists may need to be prepared for the competitive or combative nature of the medico-legal system. Together with previous literature, the present findings suggest that the expert witness role may suit the practitioners who enjoy a contest or an opportunity to perform on a professional stage or in an artistic event.

Medico-legal issues have been addressed broadly in the medico-legal literature (Braithwaite, 1997; Breen et al., 1997; Forrester & Griffiths, 2001; Mark, 2001; Purse, 2000) and by occupational therapy authors (Occupational Therapy Australia - New
South Wales, 1998; Shriver, 1989; Sterry, 1998). However, the participants specifically elucidated those issues of relevance and importance to occupational therapy opinions on work capacity, including working in an adversarial context, ensuring their assessments contribute to decisions about the quantum of economic loss, and making reasonable recommendations. Completing reports predominantly for the plaintiff or the defendant can leave occupational therapists open to speculation about bias. Providing a second opinion (i.e., one for the defendant) can be associated with increased expertise. Offering a second opinion appears consistent with the case consultancy role occupational therapists offered to solicitors in Alberta, Canada (Hall-Lavoie, 1997).

Participants identified that occupational therapists have a defined and established role in return-to-work rehabilitation programs for injured workers, thus confirming the literature on the topic (Burt, 2001; Deen et al., 2000; Helm et al., 1999; Jacobs, 1999; Jundt & King, 1999; Lo, 2000; Pohlman et al., 2001; V. J. Rice & Luster, 2002). Occupational therapy participants agreed that involvement in work rehabilitation practice helps maintain a realistic attitude to claimants’ employability and credibility in the medico-legal specialty. Participants highlighted that the rehabilitation and medico-legal systems may overlap. Participants also confirmed that the demand for comprehensive ADL assessments of injured workers for gratuitous care and assistance claims was a second major reason for referral to occupational therapists in medico-legal practice, once again confirming the literature (Harris et al., 1994; L. Kennedy, 1997a; Morgan, 1999; Occupational Therapy Australia - New South Wales, 1998).
Stakeholders: Roles and Relationships

Stakeholders are groups of people with a formal role in the medico-legal system in which occupational therapists contribute work capacity opinions and with whom they interact during medico-legal proceedings. The stakeholders who participants identified are expert witnesses, solicitors, barristers, judges, insurers, medical specialists and claimants. Each of these stakeholders’ roles and their interactions with occupational therapists in the medico-legal system are discussed in detail in the following section. To avoid duplication, some aspects of occupational therapists’ interactions with medical specialists are addressed in the next chapter, Chapter 6 (see sections 6.6 to 6.8.1) where the focus is occupational therapy expert opinions that assist the court, and differentiating the roles and opinions of occupational therapists and medical specialists.

5.7 The Role of Expert Witnesses/Experts and Their Evidence

Some occupational therapists and lawyers referred to the role of experts and their evidence in the medico-legal system, and some commented specifically on occupational therapists in the expert witness role and their interactions with other stakeholders. Sean (L) noted that occupational therapists are part of the “proliferation of disciplines with expertise available to the courts.”

The perspectives of three occupational therapists (OT), four lawyers (L), and three medical specialists (M), who commented on the expert witness role and issues relevant to occupational therapists in the role, are collated (see Table 11). The numbers of participants who commented on each issue and their professions are indicated.
Table 11

Participants’ Perspectives of the Expert Witness Role

<table>
<thead>
<tr>
<th>Perspectives on the expert witness role</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OT  L  M</td>
</tr>
<tr>
<td>1. The Role and Characteristics of the Expert Witness</td>
<td></td>
</tr>
<tr>
<td>Has specialised knowledge outside the general knowledge of most people</td>
<td>2  1  -</td>
</tr>
<tr>
<td>Assists the judge to hypothesise about the future</td>
<td>-  2  -</td>
</tr>
<tr>
<td>Must be qualified as an expert before his/her evidence is admitted</td>
<td>-  1  -</td>
</tr>
<tr>
<td>Might be called as an expert by one or both sides</td>
<td>-  1  -</td>
</tr>
<tr>
<td>Might not be called if an injury is trivial or the plaintiff has returned to work</td>
<td>-  1  -</td>
</tr>
<tr>
<td>Will often disagree with other experts about injured workers’ work capacity</td>
<td>-  -  1</td>
</tr>
<tr>
<td>2. The Rights of the Expert Witness</td>
<td></td>
</tr>
<tr>
<td>To be briefed by the barrister before trial</td>
<td>1  -  -</td>
</tr>
<tr>
<td>To receive clear instructions and feedback from solicitors</td>
<td>1  -  -</td>
</tr>
<tr>
<td>To be paid in a timely manner</td>
<td>1  -  -</td>
</tr>
<tr>
<td>3. The Responsibilities of the Expert Witness</td>
<td></td>
</tr>
<tr>
<td>To stay within his/her field of expertise</td>
<td>1  4  -</td>
</tr>
<tr>
<td>To avoid bias in his/her opinions</td>
<td>1  1  -</td>
</tr>
<tr>
<td>To ask the referring solicitor the relevant issues in the case</td>
<td>-  2  -</td>
</tr>
<tr>
<td>To provide relevant opinion evidence (cf. factual evidence)</td>
<td>-  2  -</td>
</tr>
<tr>
<td>To identify sources and methods they used to form and verify opinions</td>
<td>-  2  -</td>
</tr>
<tr>
<td>To observe standards of courtroom behaviours</td>
<td>1  -  -</td>
</tr>
<tr>
<td>To observe rules regarding expert evidence</td>
<td>1  -  -</td>
</tr>
</tbody>
</table>

(Table continues)
Table 11 (continued).

<table>
<thead>
<tr>
<th>Perspectives on the expert witness role</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OT</td>
</tr>
</tbody>
</table>

3. The Responsibilities of the Expert Witness (continued)

- To avoid answering the “*ultimate question*” before the court: 1 - -
- To be mindful of the costs of recommendations for employers: 1 - -

4. Problems for Experts

- Assessing people who distort or lie about their abilities: - 1 -
- Being challenged in court about their relevant work experience: - 1 -
- Straying outside their expertise to answer a simple question: - 1 -
- Being influenced by what they think the referring solicitor wants to hear: - 1 -

5. The Problems that Experts Might Present for the Courts

- Courts may accept the evidence of inexperienced expert witnesses: - 2 -
- Biased opinions: - 1 -
- Excessive cost to the courts: - 1 -

6. Problems Specifically Related to Occupational Therapy

- If a report on a plaintiff’s performance conflicts with video evidence: 1 2 1
- The inexperience of some occupational therapy “experts”: 2 1 -
- Favouring one side, especially the plaintiff solicitor, to gain more work: - 1 1
- An expert’s belief that a plaintiff is unemployable may influence the judge: - 1 -
- His/her evidence being dismissed if the judge thinks it is biased: - 1 -
- The profession is “polarised” around the plaintiff: - 1 -

*The ultimate question is the legal issue on which the judge must adjudicate such as the level of compensation to be awarded to the plaintiff. The decision is made by the judge based on all the evidence, some of which is not available to experts.*
One occupational therapist, Jessie, clarified that under the laws of evidence occupational therapists are not able to provide evidence on “anything of a medical nature. So they’ll ask me if I consult with the doctor in terms of my assessment and my recommendations. Well, no, I don’t. An OT report stands as an OT report.” Jessie said while she might obtain information from medical specialists, consider and refer to medical evidence in writing her reports, she does not give an opinion on what it means (e.g., blood pressure).

The reputation of experts was a concern to a participant judge. Paogong (L) stated that experts including occupational therapists should attempt “to elevate their status by recognising and adhering to their obligations.” He warned that in gaining the favour of the plaintiff solicitor they might lose the recognition of the judge. He stated that judges “don’t like biased evidence from people who, by reason of their privilege to begin with and their status, should be helping the court rather than hindering it.” In addition, he said judges quickly recognise an attitude that “is far too favourable to the person who comes before them.” He said that when bias is raised in court these experts become defensive and do not deal with questions convincingly. Finally, Paogong said, “As I’ve said, this is not limited to occupational therapists: it covers a range of experts but psychologists are the most notorious for it, incidentally.” Conversely, Paogong described the characteristics of highly regarded experts whose reports are readily accepted by the court.

Paogong: Total independence, in the sense of being fair to both sides. This is the most important feature, a lack of bias, a critical examination of the patient, that is, not adversely critical but not favourably critical, investigating both sides in other words, investigating the areas that might help the patient’s case but on
the other hand investigating areas that deserve to be investigated, that might
demonstrate that the patient is not telling the truth or is exaggerating.

5.8 Summary and Discussion: Expert Witnesses/Experts’ Roles and Evidence

A number of themes were evident in participants’ statements about expert
witnesses and their evidence, and some specific references were made to occupational
therapists in the role. The themes were the roles and characteristics of the expert
witness, their rights and responsibilities, problems for experts and the problems of
experts for the courts. The need for experts to stay within their areas of expertise was
most frequently emphasised. Expert witnesses should have a specified area of expertise
and be prepared to assist the court when it is required. This may include assisting the
judge to hypothesise about the future. While occupational therapists and lawyers agreed
on the need for expert witnesses to be briefed, there appeared to be differing views as to
which of them should initiate it. Problems associated with occupational therapy expert
witnesses may include their lack of experience, the claimant’s reported performance
being inconsistent with video evidence, and perceived bias in their evidence.

Bias was perceived as a persistent problem for experts from some professional
groups. The characteristics of highly regarded experts were identified as independence,
fairness, lack of bias, and critical examination of factors that are favourable and
unfavourable to the claimant. These findings are consistent with professional
characteristics of integrity, fairness and impartiality identified by Ward and Braithwaite
(1997). Several of the issues identified by the participants are documented in the
medico-legal literature on expert witnesses. For example, Brodsky (1991) and Ward
and Braithwaite (1997) stated that experts should adhere to evidence that is within their
areas of expertise, and Vogelsang (2001) reminded clinical social workers that as
expert witnesses they have no responsibility for the outcome of the case. However,
Saks (1990) identified that many of the problems between expert witnesses and the law have existed for a century and have not improved with time. Some of the recommendations and criticisms may be a product of the adversarial system rather than any problems relating to individual experts. Saks said expert witnesses can get “trapp[ed] in the crossfire” of legal processes at war with itself (p. 303). Thus, the alternative explanation for some perceived problems associated with expert witnesses (e.g., bias) is that some of the problems lie partly or wholly with the medico-legal system and are independent of expert witnesses including occupational therapy experts on work capacity. However, this particular explanation was not directly identified by the participants in the present research.

Although some occupational therapy authors have previously addressed issues for occupational therapists as expert witnesses from their professional perspectives (e.g., DeMaio-Feldman, 1987; Ekelman Ranke, 1997; Morgan, 1999; Potts & Baptiste, 1989; Shriver, 1989; Sterry, 1998; Wyrick & Wyrick, 1988), these issues have not been examined comprehensively or researched from the perspectives of three participant groups who are key stakeholders. These findings have extended upon the literature by clarifying several issues concerning occupational therapists as expert witnesses, thus raising awareness for the profession.

5.8.1 Characteristics of Occupational Therapy Medico-Legal Experts

Occupational therapy participants identified professional and personal characteristics of occupational therapists who are experts on the work capacity of injured workers, and who undertake the role of the expert witness. These characteristics include (a) being motivated to undertake the expert witness role, (b) having personal characteristics that are suited to the medico-legal speciality, (c) being able to identify
situations leading to stress and anxiety for experts in the medico-legal system, and (d) being able to identify factors increasing their confidence as expert witnesses.

Five occupational therapists identified the motivations of occupational therapists who undertake the role of the expert witness. Two participants indicated that there are profitable business opportunities for occupational therapists who accept the challenges of the medico-legal specialty. James stated that there are benefits for the profession in having the opinions of members scrutinised in a way that regular rehabilitation reports are not. In particular, he said justification of opinions based on research ensues. Madonna had found that medico-legal assessments are “a good break” from more intensive and lengthy rehabilitation assessments and interventions. At a personal level, one occupational therapist, Jennifer, said she enjoys “a role in getting that person a just result.”

The personal characteristics of occupational therapy medico-legal experts who are suited to the specialty were identified by six participants. They all identified the need for accuracy and attention to detail in all aspects of medico-legal services, especially the reports. Additional personal characteristics included: (a) the propensity for analytical, dispassionate judgements rather than intuitive, emotional ones; (b) strategic thinking (e.g., for preparing written and verbal responses in court); (c) maturity; (d) confidence in one’s expertise and ability to support claims concerning expertise in a curriculum vitae (CV); (c) calmness under pressure (e.g., able to thinking clearly in court); and (d) confident communication with other stakeholders, especially in the courtroom. [Note: A participant judge disagreed with “maturity” and added “integrity” to this list during the participant verification].

Without direct questioning, 13 occupational therapists identified some situations that they had found stressful as an expert witness, particularly as a novice (see Table 12). On the other hand, some more experienced or confident occupational therapists
identified some factors that they had found increased their confidence as an expert witness (see Table 13).

Table 12
Stressful Situations for Occupational Therapy Expert Witnesses

<table>
<thead>
<tr>
<th>Stressful situations in medico-legal practice</th>
<th>Number of OTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attending at court, especially initially; “fear of the unknown”</td>
<td>7</td>
</tr>
<tr>
<td>2. Feeling “attacked,” “criticised,” or “challenged” in court</td>
<td>7</td>
</tr>
<tr>
<td>3. Feeling harassed or intimidated as a female in a dominant male environment</td>
<td>1</td>
</tr>
<tr>
<td>4. Waiting outside court for up to 6 hours to be called as an expert witness</td>
<td>1</td>
</tr>
<tr>
<td>5. Having a different opinion from other specialists</td>
<td>1</td>
</tr>
<tr>
<td>6. Being unsure of the questions and issues in court</td>
<td>1</td>
</tr>
<tr>
<td>7. Lacking relevant work experience</td>
<td>1</td>
</tr>
<tr>
<td>8. Recalling “media portrayals” of courtrooms</td>
<td>1</td>
</tr>
<tr>
<td>9. Doubting one’s own ability to express important evidence in court</td>
<td>1</td>
</tr>
<tr>
<td>10. Being unsure of professional and ethical guidelines for occupational therapy</td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of these factors relate to performance in the courtroom. A participant judge related confidence (described as “lack of self-consciousness”) to competencies of experts. Quotes from Madonna, Barbara and Donald are used to exemplify several occupational therapists’ thoughts on feeling confident, anxious or fearful in court. It took Madonna 12 months of regularly being an expert witness for her anxiety to diminish.
Madonna: *The best experiences have been when I have been totally sure, absolutely no question in my mind that what I’ve written is right, that it truly reflects the person’s capacities and abilities and future and that I have been easily able to justify it in terms of these being clear clinical observations with a clear history, very exact history. ... It doesn’t matter what they say I know I am right.*

Barbara: *And I have to say that even though one is not there to defend oneself it still gives you butterflies in your stomach. This is pretty heavy stuff so there is some anxiety there.*

Donald: *You stick people in a foreign environment. You set it up as a war zone with plaintiff and defence in a foreign environment that 95% of people in Australia have never been involved with. You put them on a foreign planet, and then you grill them, and frighten them and scare them and somewhere in there you hope that justice is served by getting great answers out of them.*

The need for confidence is supported by an observation recorded in the Researcher Log (Extract 93 dated January 16, 2003) that noted “those more experienced occupational therapists who engage in medico-legal work appear to be confident and assertive as demonstrated by their tone, fluency and clearly expressed views in the interviews. Some other less experienced participants or those who only occasionally undertake medico-legal assessments appear less confident.”
Table 13

Factors Increasing the Confidence of Occupational Therapy Expert Witnesses

<table>
<thead>
<tr>
<th>Factors that increase confidence</th>
<th>Number of OTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having knowledge and experience of the legal proceedings</td>
<td>2</td>
</tr>
<tr>
<td>2. Thinking clearly under pressure</td>
<td>2</td>
</tr>
<tr>
<td>3. Receiving positive feedback from barristers about their courtroom performance</td>
<td>2</td>
</tr>
<tr>
<td>4. Being readily able to justify the report contents, especially the recommendations</td>
<td>2</td>
</tr>
<tr>
<td>5. Feeling comfortable, or having an elevated mood after performing well in court</td>
<td>2</td>
</tr>
<tr>
<td>6. Being adequately prepared for court, including being briefed adequately</td>
<td>2</td>
</tr>
<tr>
<td>7. Having developed one’s own reporting format</td>
<td>1</td>
</tr>
</tbody>
</table>

Five occupational therapists indicated that some in their profession do not undertake medico-legal assessments voluntarily or find any pleasure in doing them. They gave three reasons for occupational therapists avoiding medico-legal assessments. They are (a) the pressure to justify everything that is written, (b) being anxious or fearful about defending opinions under cross-examination in court, and (c) the disruption to a private practice when attending court. However, six occupational therapists noted that reports of treating rehabilitation occupational therapists may be subpoenaed, so not being a voluntary expert witness is not a guarantee that occupational therapists will not be required to assist the court. James and Jessie emphasised the importance of writing all rehabilitation reports knowing that they could potentially be used in medico-legal proceedings.
5.9 Summary and Discussion: Professional and Personal Characteristics

Occupational therapists and one lawyer highlighted professional and personal characteristics of occupational therapy experts in the medico-legal system. These characteristics were (a) being motivated to undertake the expert witness role, (b) having personal characteristics suited to the medico-legal specialty, (c) being able to identify situations leading to stress and anxiety in the medico-legal system, and (d) being able to identify factors increasing their confidence in the medico-legal specialty.

The motivation for undertaking the role of expert witness included receiving financial rewards commensurate with the challenges, and that such scrutiny of the profession could prompt higher standards and research. Desirable professional and personal characteristics for the role included accuracy and attention to detail, integrity, maturity, calm and confident communication, and strategic, analytical and dispassionate thinking. A number of stressful situations for occupational therapy expert witnesses were consistently identified by the majority of occupational therapists. One situation related to being in an unfamiliar situation and another was feeling threatened in court by barristers’ cross-examination. It is conjectured that some occupational therapists find this departure from a collegial approach disconcerting and even distressing, promoting a negative or defensive response to later requests.

On the other hand, a number of experienced and confident occupational therapy expert witnesses identified factors that increased their confidence as expert witnesses (e.g., being able to think clearly under pressure, and being readily able to justify the contents of reports, especially the recommendations). A participant judge related confidence to an expert witness being competent, and so provided an alternate interpretation. Stressful situations for expert witnesses have been identified for other professions, such as medical practitioners (Breen et al., 1997), psychologists (Brodsky, 1991) and social workers (Vogelsang, 2001). Breen et al. (1997) noted that medical
practitioners can be “upset” by an adversarial cross-examination that they feel may reflect on their competency and integrity, but advised them to see themselves as accountable and not become hostile. Brodsky (1991) identified that expert witnesses may feel attacked, threatened or intimidated by hostile and cynical cross-examining lawyers who are attempting to reduce the impact of their evidence. Vogelsang (2001) said that, despite a 100-year history of clinical social workers going to court, they “march to the stand like martyrs about to be burned at the stake” (p. 1).

While King et al. (1998) and S. Strong (2002) suggested the importance of personal factors when experts assess work capacity, this is the first known research to identify the professional and personal characteristics considered important for occupational therapists who practice in the medico-legal specialty. The findings indicate that, in common with other health and welfare professionals, some occupational therapy expert witnesses may experience stressful aspects of the role. Furthermore, participants indicated that various factors may increase confidence and influence whether occupational therapists are willing to participate as medico-legal experts.

5.10 Solicitors’ Medico-Legal Roles and Interactions with Occupational Therapists

The three participant groups described the role of solicitors from their perspectives. In particular, their interactions with occupational therapists are described.

5.10.1 Solicitors: Occupational Therapists’ Perspectives

In identifying the solicitors’ roles in the medico-legal system, occupational therapists indicated an important difference between their own roles in the medico-legal
system and rehabilitation. Both Jessie and Jennifer stated that it is the solicitors and not the injured persons who are their clients in the medico-legal system. Jessie said it is “whoever’s paying your bill is the person you’re working for. ... It’s really important not to get into an advocacy role.” Jennifer said, “I’ve got to be able to produce what the legal firm wants for a price they’re able to pay.”

Lucy and Stan said that solicitors ask questions to elicit statements about economic loss and they prefer statements of loss expressed in terms of quantifiable amounts, such as percentage ratings. They sometimes want occupational therapists to state the person’s losses as a percentage of impairment according to the AMA guides (2001). Stan said that he answered solicitors’ questions within occupational therapy conceptual frameworks and urged other occupational therapists to do the same.

Occupational therapists explained how plaintiff and defendant solicitors might ask different sets of questions. Sue said that reports for the defendant are more likely to emphasise the injured person’s abilities and recommendations to assist them to return to work, thus minimising loss. Shaunagh said that plaintiff solicitors “tend to try and maximise the claim,” and sometimes insisted that plaintiffs needed resources that “were not really needed.” John and Antionette observed that referring solicitors are selective about the occupational therapists they choose to undertake certain assessments. John said that he assumed solicitors wanted particular information and the recommendations “couched” in a certain way. Solicitors might also be selective about using the reports they request. John said, “One solicitor explained to me they just find a report that suits them.”

Some occupational therapists marketed their services to solicitors to increase referrals. Antionette said that many solicitors “look for people like us but they can’t find us. So it’s a matter of marketing.” Antionette said that lawyers value occupational
therapists’ expertise and marketing to them would make her practice workload “skyrocket.” Four occupational therapists described their methods of marketing to solicitors. Completed reports are perceived as a primary method. Other marketing methods are personal recommendations by barristers, and periodic phone calls to solicitors to ensure reports meet their needs. Four occupational therapists highlighted some marketing difficulties. These include: (a) protecting commercially sensitive methods from competitors when medico-legal reports are frequently distributed to a number of stakeholders within a small pool; (b) fee setting for more specialised reports, for example, hand therapy and driving assessments; and (c) identifying ways to increase referrals to specialised private practices. Two occupational therapists who were in specialised private practices suggested an increased role for the professional association in marketing their occupational therapy medico-legal services. However, a judge participant who responded during participant verification stated, “Acceptance by the court is the best marketing practice and better than saying what the solicitor wants.”

Five occupational therapists reported at least one incident of delayed payment by solicitors, many soon after entering private practice. Three participants had required legal approaches to resolve the problem, one of which was outstanding for 7 years. They had introduced precautions to ensure payment. The precautions included: (a) not releasing reports until payment is made; (b) refusing to do “spec” work, that is, payment only if the case wins; (c) dating and writing verbatim what is agreed over the telephone; (d) putting a 2% surcharge on bills not paid after 30 days; and (e) itemising accounts of requested activities such as travel and time spent reading medical and paramedical files. Unlike some of her colleagues, Sophie said she did “spec” work but used an incentive package whereby she charges “significantly less” if she is paid within 90 days. She pointed out that, in comparison to solicitors, insurance companies
paid promptly for defendant work. Yet payment could be a pleasant part of interactions with solicitors. Antionette said there was an incentive for occupational therapists “if they were paid $400.00 for an hour’s work.”

5.10.2 Solicitors: Lawyers’ Perspectives

In this research, the lawyers’ views on solicitors’ roles appeared related to which of the two opposing parties they represent. For example, Martin stated that plaintiff solicitors need to obtain as much settlement money as is due to their clients for past and present losses because this is the only opportunity they will have to do so. Martin said, “I have to be a bit pessimistic or conservative. And I can’t simply assume that that person will make a good recovery, even though that might be the doctor’s best wishes.” Two defendant lawyers asserted that, compared to plaintiff solicitors, they consider the best interests of the plaintiff. These defendant solicitors said that plaintiff solicitors are primarily concerned about financial settlements and that if the settlements did not reach plaintiffs’ expectations the solicitors could be sued for negligence. Defendant solicitors blamed some plaintiff solicitors for promoting beliefs that the plaintiffs are unemployable, and for the “blatant” ways some of them appear to script their clients’ symptoms (Scully). However, Sean said that the stance and comments of solicitors on either side could influence occupational therapists at the referral stage.

Sean: Do OTs try and please their client? I think, yes, they do. I don't know whether it's intentional, sometimes it's just the way the things fall, and sometimes it's the information they're supplied with. You know, if the insurance company says, ‘This person, we think, is a ratbag, blah, blah, blah.’ That can't help but colour the way you see things. Equally, if the plaintiff lawyers say,
‘This bloke’s a terrific bloke, he’s really trying hard to get back [to work], what do you think you can do?’

Solicitors indicated their role in initiating referrals to occupational therapists. Scully noted that occupational therapists are assessing clients with “fairly specific instructions from the lawyers.” Max said he initiates 90% of his referrals to occupational therapists and medical specialists initiate the remainder. Defendant solicitors might not request a second occupational therapy report to counter one requested by the plaintiff solicitor if, as Jill said, it is “obvious” what the person’s residual capacities would be, or if she would “only end up with a report that doesn’t help you one tiny little bit and, if anything, it will probably just support the plaintiff’s position.” Instead, Jill trusted the impression she gained first hand at mediation. Jill said, “You can gauge to some extent their demeanour and as to whether they’re heaving and sighing and moving around, as to how genuine their complaints are.” In this and other references Jill appeared to trust her own observations of the claimant’s work capacity rather than relying only on that of an occupational therapist.

5.10.3 Solicitors: Medical Specialists’ Perspectives

Three medical specialists were critical of the influence exerted by the party paying for the report, including the insurer. Matthew and Edmond said that “pro-plaintiff” solicitors tend to use the same “pro-plaintiff” medical practitioners and occupational therapists. Edmond said that some lawyers continue to seek opinions of occupational therapists whose evidence has been shown to be incorrect or biased in video clips at trial. He spoke strongly against this use of sympathetic professionals, describing it as “second line advocacy” undertaken by commercial enterprises. He
related it to pro-plaintiff work paying more than defendant work paid for by insurance companies.

5.11 Summary and Discussion: Solicitors’ Medico-Legal Roles and Interactions with Occupational Therapists

Participants perceived that solicitors, as the primary source of referrals have some influential roles and interactions with occupational therapists in the medico-legal system. All participant groups perceived that solicitors’ interactions with occupational therapists and other stakeholders in the medico-legal system are directly related to whether they represent the plaintiff or defendant. Both plaintiff and defendant lawyers expressed the view that their stance is in the long-term interests of plaintiffs. According to the side they represent and information they want, solicitors can be selective about the occupational therapists to whom they refer. A key finding from the three participant groups is that solicitors are aligned with either plaintiff or defendant sides, and that accepting referrals can influence perceptions of a similar alignment by occupational therapists. The findings are partially in contrast to Mark (2001) who represented the plaintiff solicitor as protecting the rights of the injured person, and with Solon (2001) who suggested that the quality of the expert reflected on the reputation of the solicitor. Some occupational therapists are interested in marketing their medico-legal services to solicitors and perceive their reports as a principal marketing method. In a survey of lawyers and occupational therapists, Hall-Lavoie (1997) also identified that solicitors were the stakeholders who made most of the referrals to medico-legal occupational therapists.

In the current research occupational therapists identified that solicitors are responsible for the financial aspects of their clients’ cases. They have learnt to take precautions to be promptly paid for their services. Consistent with the findings of this
research, the medico-legal literature represents the solicitor as responsible for gathering information, organising and conducting the claim including communication with experts, barristers, their clients and other solicitors (Hayne, 1995), and as the stakeholders who have the most direct contact with their client (Dimond, 1999).

The findings of this research support the pivotal role of solicitors in facilitating or otherwise influencing the contribution of occupational therapists to work capacity medico-legal decisions. In addition, the findings of the research extend the previous literature on the referral relationship.

5.12 Barristers’ Medico-Legal Roles and Interactions with Occupational Therapists

Barristers including QCs and SCs were mentioned frequently by occupational therapists and less frequently by lawyers. Barristers were represented as having two influential roles. Sean (L) said barristers “advise on and run cases - both informal settlement conferences, mediations - we call that 'alternative dispute resolution' - and formal settlement procedures.” The second role, formal settlement procedures, includes trials before the judge and appeals to the Court of Appeal. Barristers may advise solicitors to obtain an occupational therapy opinion and identify suitable occupational therapists. They were perceived as understanding the value of occupational therapy opinions. Sean, a barrister, said “in the last 5 years in particular, I think, occupational therapists have come into a much stronger focus for the services they can provide in assisting the legal profession and the courts in assessing people's residual capacities.” Barristers may also request that occupational therapists brief them about certain matters in relation to the primary reports on work capacity.
In the second role, barristers examine or cross-examine occupational therapists in courts. Paogong said, “Barristers usually cross-examine on the basis of advice of another OT, or the perceived bias, or opinions contrary to the evidence.” During cross-examination occupational therapists, at times, described barristers’ manners as “brusque” or “aggressive” (see section 6.10.4.1 for strategies barristers used during trials). Donald (OT) described the role of QCs in the Supreme Court.

Donald: [In] the Supreme Court you are probably more likely to get someone like a Queen’s Counsel ... and they didn’t get there by being nice. They are ruthless, they know what they’re talking about, they’ve seen more personal injury trials than you and I have had breakfasts. Nine times out of ten they know what your response is going to be before they ask you. They’re quick on their feet, they understand medical terminology, they understand OTs, they understand function and disability, and understand basic concepts of work rehabilitation.

In the Supreme Court you are going to get Queen’s Counsels who are getting paid 3, 4 and 5 thousand dollars a day. You can bet your bottom dollar they’re going home at night reading your report and reading up on the literature to make sure they know how to take your opinion apart piece by piece.

5.13 Summary and Discussion: Barristers’ Medico-Legal Roles and Interactions with Occupational Therapists

Findings in the thesis about barristers’ roles and interactions with occupational therapists suggest that many barristers understand the value of occupational therapists’ medico-legal opinions on work capacity. Barristers’ roles include identifying
occupational therapists to provide opinions for formal and informal medico-legal proceedings, and examining or cross-examining occupational therapists in courts. In this way, this group of lawyers play an important role in the way occupational therapists’ personal injury opinions are regarded in medico-legal proceedings. This point is expanded upon in section 6.10.4.1 on barristers’ courtroom strategies. The literature supports the role of barristers as appointed by solicitors and as advising on and running cases in court (Hayne, 1995). Previous literature has placed emphasis on understanding the formal role of barristers in cross-examining occupational therapy experts (Shriver, 1989). The present research extends upon the previous literature by explaining the nature of barristers’ influence and their interactions with occupational therapists in personal injury cases.

5.14 Judges’, Commissioners’ and Magistrates’ Medico-Legal Roles and Interactions with Occupational Therapists

From their interactions with judges, commissioners or magistrates, occupational therapists perceived judges, and their lower court counterparts, as influencing their contribution in several ways. Their perspectives are compared with those of lawyers in Table 14.

Four lawyers and three occupational therapists identified that the judge’s role was making decisions about claimants’ work capacity and economic loss. Martin (L) emphasised the way judges balance between competing opinions of “a stable of occupational therapists that [insurers] use who are sympathetic to their side of things” and “a stable of occupational therapists who are sympathetic to [the plaintiff’s] side of things.” Martin said that when two occupational therapists “both examine the work-site, both interview the plaintiff, both have access to the same medical reports, and
come up with different conclusions," the judge examines the reports, and arrives at a decision.

Table 14
Occupational Therapists’ and Lawyers’ Perceptions of the Role of Judges

<table>
<thead>
<tr>
<th>Occupational therapists</th>
<th>Lawyers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judges can:</td>
<td>Judges may:</td>
</tr>
<tr>
<td>1. Keep control of the courtroom</td>
<td>1. Determine experts to assist the court</td>
</tr>
<tr>
<td>2. Keep barristers “in check” (Alex, OT)</td>
<td>2. Require experts to assess work capacity</td>
</tr>
<tr>
<td>3. Facilitate contributions of expert witnesses</td>
<td>3. Decide weighting of work capacity opinions</td>
</tr>
<tr>
<td>4. Question expert witnesses for up to ½ hour</td>
<td>4. Be viewed as sympathetic to the plaintiffs</td>
</tr>
<tr>
<td>5. Protect expert witnesses from undue duress</td>
<td>5. Pre-empt appeals of dissatisfied plaintiffs</td>
</tr>
<tr>
<td>6. Protect the rights of plaintiffs</td>
<td>6. Decide between competing sympathies</td>
</tr>
<tr>
<td>7. Follow their own lines of inquiry</td>
<td>7. Have worked at the bar, and for both sides</td>
</tr>
<tr>
<td>8. Decide which expert evidence they prefer</td>
<td>8. “Try very hard” to avoid bias (Paogong)</td>
</tr>
<tr>
<td>9. Have individual areas of expertise</td>
<td>9. Periodically favour one side (Scully)</td>
</tr>
<tr>
<td>10. Develop a view of an expert’s credibility</td>
<td>10. Develop their own expertise, so may not</td>
</tr>
<tr>
<td>11. Require experts to address them respectfully</td>
<td>require expert advice in all matters</td>
</tr>
</tbody>
</table>

In contrast to the formal roles undertaken by judges, some informal aspects of their roles were identified. Scully (L) said that, in the courtroom, judges would err in favour of the “injured person to make sure that they are compensated ... rather than erring on the side of the insurance company who you’re not necessarily going to feel any sympathy for.” In this way, Scully said the court’s attitude favours inexperienced
occupational therapists “reporting for the plaintiff.” Donald (OT) said that barristers and solicitors who run trials take advantage of personal differences between judges when they “try to have their case put on the call-over when they know certain judges are on, so they match their case to the judge.” James (OT) had a different perspective. On one occasion he said he gained “the impression the magistrate was not ‘pro the employee’ but trying to ensure that the employee had the best possible case to put forward and find out whether he could or couldn’t do the job.” Similarly, Rod (OT) indicated that if judges express a preference for the evidence of one expert over that of another, they provide a rationale for their decision.

Rod: I have read judgements where the judge will point out in a transcript that he acknowledges that one OT is a qualified OT, and qualified to write reports, but he or she prefers the evidence of the OT who has experience, say with ABI.

Paogong identified that the judge’s “interest is to arrive at the truth and to do justice.” Another role of judges is in hypothesising about the future.

Paogong: The judge’s task is ... to try to reach the correct verdict and that often entails trying to foresee the future ... in relation to the patient’s prospects of working, or, if working, what limitations there will be or, alternatively, if working, what discomfort or pain might be suffered as the result of that injury.

The researcher asked about one occupational therapist’s aim to be quoted in the judge’s report, believing this was praise. Paogong clarified, saying that being quoted meant that the evidence is accepted; it is not challenged. Paogong said, “It will be in the judgements where the matter has been contested and gone to judgement and ... the
Three occupational therapists reported addressing a judge. The issues they raised with a judge were (a) feeling uncomfortable to answer a question outside their area of expertise, (b) noting the difference between impairment and functional capacities because of its bearing on the case, and (c) drawing attention to differences between the defendant’s photographic evidence at the trial and documented evidence recorded earlier at a work-site assessment. However, Donald said communicating with judges is not always easy, as “it is very difficult as an expert to put expert things into laymen terms succinctly and quickly.”

5.15 Summary and Discussion: Judges’, Commissioners’ and Magistrates’ Medico-Legal Roles and Interactions with Occupational Therapists

Participants perceived that judges have three roles in which they interact with occupational therapists in personal injury cases that go to trial. The roles are (a) controlling courtroom proceedings, (b) weighing evidence to reach rational decisions, and (c) hypothesising about the future. The first two roles are consistent with Breen et al.’s (1997) description of the judge as an umpire in a contest between opposing parties, and with references to the judge’s “ratio decidendi” (reasons for the decision) as the main principles that are set out in a case (Dimond, 1999; Forrester & Griffiths, 2001). Participants perceived judges as ultimately the person who needs to be convinced about the impact of the injury on the injured worker, and as providing the plaintiffs with opportunities to make their case. This finding is consistent with Hayne (1995) who described the judge as hearing the evidence and having the responsibility for arriving at a decision which includes the quantum of a case (Braithwaite, 1997). Two defendant lawyers perceived judges as favouring the plaintiff and accepting evidence of
occupational therapists, including inexperienced ones, who report for plaintiff solicitors. In contrast, Rogers (2000) portrayed judges as taking a range of claimant-related factors and medical evidence into account. Braithwaite (1997) stated that at trial the full impact of the accident on the person and his/her family in the future is easily overlooked. Adams et al. (2003) documented these social and economic impacts of workplace injury and illness in case study research. Participants in the present research said that judges may need occupational therapists’ expert opinions to make decisions about claimants’ work capacity, and that occupational therapists should attempt to ensure their evidence is heard and accepted by the judges. Three occupational therapists reported speaking directly to a judge to clarify matters in relation to their evidence. The findings identify three roles of judges in which they interact with occupational therapists in personal injury cases that proceed to trial. These findings do not appear to have been previously documented in the occupational therapy literature.

5.16 Insurers’ Medico-Legal Roles and Interactions with Occupational Therapists

Fourteen occupational therapists and three lawyers referred to insurers in the medico-legal system. Insurers operate under legislation relating to (a) compulsory third party motor accident insurance, (b) workers’ compensation insurance, and (c) public liability insurance. Depending on the legislation under which they operate, insurers might have dual responsibilities for rehabilitation of injured people of working age and payment of compensation on behalf of the insured party (e.g., employer, or at-fault motor vehicle driver). Jill (L) had a high regard for one workers’ compensation insurer for processing claims quickly, rehabilitating injured workers they insure, and for offering claimants prompt vocational assistance and retraining. Through employing occupational therapists and other health professionals as advisors, insurers engage
occupational therapists to provide return-to-work programs on their behalf to the injured person, if liability is accepted. In another role, insurers consider how occupational therapy reports can be used in mediation or litigation. Scully (L) explained this second role.

Scully: *In a typical case where the plaintiffs will obtain an OT report, we will look at it and decide whether or not what’s in it is really that damaging for us, do we need to counter it, do we agree with it, do we disagree with it, or do we think it’s reasonable or not. Then we make a decision whether or not we need to get a defendant medico-legal [report] to counter it. More often than not we need to.*

Two occupational therapists and one solicitor suggested that cost containment is a major consideration of insurers and consequently there is conflict with their provision of client-centred work rehabilitation and equitable financial settlement in the medico-legal system. Although Sophie (OT) had experience of insurers settling claims quickly, especially when experts agreed, Shaunagh (OT) referred to situations when this did not occur. She believed that a dispute over financial settlement is not easily settled if “*one side is thinking the person is a victim, and the other side is thinking that the person is a maximiser.*” Further, Shaunagh had found that the role of rehabilitation advisers, implemented by insurance companies, has changed them “*from understanding the rehab process to becoming really good with claims management issues.*” Shaunagh stated that there is a conflict between rehabilitation and claims management, as “*one is about spending money, believing the person, validating them, trying to help them achieve what they want to achieve, and the other’s about trying to save money.*” However, Scully (L) perceived that the role of an occupational therapy advisor for an
insurance company is principally focused on clients and their successful work rehabilitation. Scully’s view of the way insurers select occupational therapists to report for the defendant also differs from that expressed by occupational therapists (see section 5.11).

Scully: The plaintiffs tend to use the ones who are going to give them what they want to hear, and we are then forced to use the ones who are going to try and pull that opinion down or take the other approach. So that eventually, we might meet in the middle of the road.

Scully (L) and Jill (L) had both experienced courts that were sympathetic to the plaintiff. Scully said insurers are perceived “as professional litigants … with pots of money.” But Jill said, “It is easier for insurance companies to pay up. … Insurers are making a decision on a commercial basis rather than necessarily on the merits of the case.” She explained that if it is going to cost an insurer $25,000 to run a District Court trial, it is easier to pay the plaintiff $20,000, even if it is only worth $10,000, because they will save $5,000. Still, Jill believed that defendants and insurers should challenge excessive claims in court or risk pushing up premiums by “paying out double what they could have paid out had they actually had the gumption to take it to trial.” Furthermore, Jill said insurers need the courts to say, “Well, no, enough is enough, and it was an accident.”

5.17 Summary and Discussion: Insurers’ Medico-Legal Roles and Interactions with Occupational Therapists

Participants identified that insurers have two principal roles in which they interact with occupational therapists. These roles were contracting occupational
therapists to undertake occupational rehabilitation programs, and countering occupational therapists’ reports requested by plaintiff solicitors. Two defendant solicitors perceived that courts, plaintiff solicitors and occupational therapists reporting on the claimant’s capacities favour the plaintiff side, resulting in insurers paying higher levels of compensation on behalf of the insured party (e.g., employer) than the claimants’ injuries warrant. However, some occupational therapists perceived that insurers are overly concerned with saving money and insufficiently concerned with the plaintiff’s needs. These findings are consistent with the literature on insurers that emphasises their interest in reducing compensation costs (Mark, 2001; Schultz et al., 2000), and as influencing the assessing occupational therapist to the disadvantage of the claimant (Shriver, 1989). This research has identified some divergent views on insurers especially with regard to the equity of financial settlement they offer to claimants.

5.18 Medical Specialists: Lawyers’ Perspectives

Lawyers and occupational therapists made frequent references to the role of medical specialists as experts, comparing it to the role of occupational therapists. The occupational therapy references to medical specialists are contained in sections 6.6 and 6.8.1 where occupational therapists’ areas of expertise are examined in relation to that of medical specialists in more detail.

Lawyers identified the role of medical specialists as providing opinions on impairment, risk of re-injury and prognosis for the courts. Martin said, “Courts will invariably want to have a medical opinion as the fundamental basis.” Approximately 90% of Scully’s cases have an orthopaedic report. An advantage of orthopaedic surgeons’ reports was their use of standardised impairment ratings as this made it easy for lawyers to calculate economic loss. Four lawyers said referrals to occupational
therapists usually follow those to medical specialists, but Max reverses the referral order on occasions.

Three lawyers emphasised their high regard for medical specialists’ opinions. Max said he accepted a medical specialist’s “attack” on what he regarded as a “flawed” occupational therapy medico-legal report. Scully considered medical specialists are less polarised than occupational therapists and less inclined to be biased according to whether they are reporting for the plaintiff or defendant, although she conceded, “Having said that, there are some doctors who learn that lesson in court too.” Paogong considered that occupational therapists should accept the medical opinion (e.g., on pain) and add to it, rather than duplicate aspects of it.

Paogong: The therapists should simply say, ‘I have read the reports of Doctor so and so, dated so and so and this report will assume these contents.’ That wouldn’t prevent them saying, ‘Well, the pain in the right ring finger severely inhibits this person’s dancing ability … so he will not be able to be a famous dancer.’

In contrast, four lawyers stated the limitations of medical specialists’ practices and expert opinions compared to those of occupational therapists regarding a person’s employability. The principal limitations were: (a) a perceived reluctance to treat the plaintiff before settlement; (b) a tendency to express the claimants’ abilities as a percentage, thus disregarding individual and occupational differences; (c) impairment ratings do not provide practical information about functional capacity and employability as provided by occupational therapists; (d) orthopaedic surgeons’ lack of skill in and time taken to assess functional capacity; and (e) an underestimation of the impact of a condition on employment. To Scully, “an orthopaedic report that says
someone who has a 5% PPD [Permanent Partial Disability] is not as useful. ... What does that restrict them from doing? What can they do and what can’t they do with that sort of disability?” Martin also recognised this problem.

Martin: If I have a 10% disability of my spine, that might not effect my employment at all as a solicitor, but if I’m a labourer, 10% impairment of my spine is very significant and might have a big impact on my ability to work.

Furthermore, some lawyers did not regard orthopaedic surgeons as authorities on future work capacity. Sean’s concern was that although some orthopaedic surgeons still purport to know what jobs a person is suitable for, “an orthopaedic surgeon's not in any position to say whether a person could engage in this activity on an ongoing basis.” Martin added that to some orthopaedic surgeons, “unless you’ve actually severed the spinal cord, or [unless] you have a degenerative disease, there’s not a problem, you’ll be able to go back to work!”

5.19 Summary and Discussion: Lawyers’ Perspectives on Medical Specialists

Lawyers perceived that medical specialists have the primary role as medico-legal expert witnesses for the courts. Medical specialists appeared to be accepted authorities on impairment, risk of re-injury and prognosis. Some lawyers indicated they did not accept that orthopaedic surgeons are authorities on the plaintiff’s functional capacity or employability, and instead they value occupational therapists’ opinions on these issues. These complementary and clearly defined roles that lawyers ascribed to medical specialists and occupational therapist are consistent with the ICF model (WHO, 2001) in which impairment, activities and participation are separately described
and placed on a continuum. These views are supported further in sections 6.4 to 6.6 where the three participant groups’ describe occupational therapy areas of expertise that assist the courts. This is the first known literature to record the value and limitations of medical specialists’ expert opinions from the viewpoint of the three participant groups.

5.20 Claimants in the Medico-Legal System

The focus of this section will be the claimants who are assessed by occupational therapists for medico-legal work capacity opinions. The perspectives of each participant group regarding claimants will follow the claimants’ profile.

5.20.1 Claimants’ Profile

Although individual occupational therapists reported assessing diverse conditions within their individual expertise, there was consistency between the three participant groups regarding the medical conditions of claimants generally assessed by occupational therapists. Most claimants have musculoskeletal injuries, experience chronic pain, and sometimes have multiple injuries. Low back injuries and neck injuries such as whiplash constitute the majority of conditions. Eight, or nearly half, of the occupational therapists also reported assessing claimants with cognitive impairments arising from TBI. The conditions of other claimants included spinal cord injury, hand injury, sensory loss and obesity. Obesity was mentioned by three participants in relation to workplace discrimination. If claimants with psychiatric or psychological disorders are referred to occupational therapists for a work capacity assessment, the claimants’ physical capacities are the main assessment focus.

A number of participants addressed the severity of claimants’ injuries. Most injuries experienced by claimants and referred to occupational therapists appear to be of
medium severity with some equivocal aspects to them. Stan (OT) said, “I don’t perceive that there is a huge debate going on out there about serious injuries.” A member of each participant group concurred. Yet, four occupational therapists noted that they receive referrals for injuries ranging from very minor to very severe, that is, “catastrophic.” Jennifer said that persons with “puny little injuries” might have been ill advised that they would make a lot of money. David (M) said “motivation too, that’s a big thing,” indicating that severity of injury is only one indicator of a person’s work capacity. Although people with severe TBI who have incurred unequivocal economic loss do not require work capacity assessment, people with severe orthopaedic injuries do. Scully (L) also said, “What is increasingly common are soft tissue injuries with big psychological overlay that become big claims, expensive claims.”

Claimants aged 30 to 50 years are commonly assessed; however, occupational therapists with expertise in developmental paediatrics and/or severe injuries may assess the future work capacity of claimants as young as five years. The occupations of family members are used as guides to the child’s potential employment, but for the injury. Although two occupational therapists indicated the slight majority of their clients were male, the participants, in general, did not refer to the gender of the claimants. The occupations in which claimants had previously been employed typically included heavy industry (e.g., mining and construction), trades, clerical and process work. Claimants’ jobs included unskilled, semi-skilled, skilled work, and the professions. Claimants from interstate or overseas could have their injuries assessed for medico-legal proceedings in any Australian state or federal jurisdictions. Jessie (OT) said, “The case has to be heard in the place where the injury occurred.”
5.20.2 Occupational Therapists’ Perspectives on Claimants

Descriptions of interactions between assessing occupational therapists and claimants indicate that the way they relate in the medico-legal system and rehabilitation contexts differ. In the medico-legal system, it is unprofessional to discuss assessment findings with the claimant or claimant’s family, and occupational therapists assessing claimants for defendants can meet with resistance because of perceptions of bias.

The occupational therapists displayed three discernible attitudes to claimants. The first attitude is sympathetic to claimants. Six occupational therapists predominantly expressed this attitude. It included beliefs that (a) claimants are in genuine pain, (b) injuries can have a profoundly negative impact on their lives, (c) most people are honest and consistent in their performance, (d) their interests and self-assessed capacities should be taken into account when recommending suitable employment to improve outcomes, and (e) a reason that claimants’ families sue on behalf of a family member is to meet their daily needs following a severe injury. Jennifer stated, “What a rotten road some people have to tread! I know some doctors do treat them and other people do treat them as though they’re second class citizens.” Not only did this group of occupational therapists not use the words “malingering” or “faker,” but several also believed that some other professionals who did so were misguided. Instead, Barbara used terms such as “coping” and “adjusting” in accounting for discrepancies between expected and reported outcomes of medical and rehabilitation treatment.

A second attitude regarding claimants was expressed by six occupational therapists. This attitude is that claimants’ work capacities are ambiguous due to influences in the medico-legal system. Occupational therapists who held this attitude were uncertain when claimants were telling the truth, or might “strongly disagree” with the claimants’ assessments of their own capacity. John queried, “If he could only drive 15 minutes was that his real capacity or was he trying to maximise his
Some members of this second group of occupational therapists expressed a third attitude, namely, that claimants might deliberately understate their work capacities. This third attitude included viewpoints that claimants do not tell all they can do and attempt to maximise their claims or symptoms. Although several of this group of six occupational therapists also clarified that they do not use words like “malingering” or “dishonesty,” the attitude expressed by this group of occupational therapists related to concerns about the veracity of some clients’ reports, based on the principle that perceptions of increased disability are likely to result in increased compensation. Regardless of the restricted performance of individual claimants at assessment, John and Lucy firmly believed most claimants endeavour to regain their work capacities and to resume normal activities and, consequently, their actual capacities will typically be higher than those demonstrated at assessment. For example, John said one truck driver, despite claiming he could not drive, simply resumed driving after receiving his “pay-out.”

5.20.3 Lawyers’ Perspectives on Claimants

Lawyers referred to the claimant, or plaintiff, frequently in the interviews. Analysis revealed that defendant and plaintiff lawyers have divergent attitudes to claimants. Defendant lawyers depicted claimants as influencing the amount of their settlement while plaintiff lawyers emphasised a more passive role for them (see Table 15). Two defendant solicitors referred to occupational therapists’ role in assessing claimants whose work capacities were ambiguous. One of whom, Jill, provided a reason so many occupational therapy referrals are for claimants in this category. She said it was not necessary for occupational therapists to assess most “genuine” plaintiffs as the impact of their injuries is clear to the courts. However, Jill said, “In the case where you have some suspicions as to what the plaintiff is capable of doing, I think
often they’re quite capable of manipulating the physical tests so that they reflect the result that they ultimately want.” Scully held a dissimilar viewpoint, saying that in ambiguous cases and cases where malingering or exaggeration is suspected, occupational therapists could help clarify claimants’ capacities. Indeed, Paogong said it is the responsibility of occupational therapists to test if a plaintiff is not telling the truth or is exaggerating.

Table 15

Lawyers Perspectives on Plaintiffs

<table>
<thead>
<tr>
<th>Lawyers perceptions of plaintiffs</th>
<th>Defendant</th>
<th>Plaintiff</th>
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<tbody>
<tr>
<td>1. Are not always advantaged psychologically by the litigation process</td>
<td>2</td>
<td>1</td>
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<tr>
<td>2. Are primarily concerned about the amount of compensation</td>
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<td>1</td>
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<tr>
<td>3. May sue solicitors who do not secure expected compensation</td>
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<td>1</td>
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<tr>
<td>4. May be given lists of symptoms and impacts the court could expect</td>
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<td>1</td>
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<tr>
<td>5. May believe they will receive less if they return to work</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>6. Are influenced by their solicitor and medico-legal experts</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>7. Give evidence with “more weight than any medical evidence” (L2)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>8. Sometimes give reports of doubtful veracity</td>
<td></td>
<td>1</td>
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<tr>
<td>9. May “have adopted the persona of a victim or an invalid” (L5)</td>
<td></td>
<td>1</td>
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<tr>
<td>10. Are more likely to “lose control” of events at trial than mediation (L5)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>11. Are legally obliged to mitigate their losses through work rehabilitation</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>12. Get “lost in this process” (L3), if there are competing experts’ opinions</td>
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Two lawyers described the negative effects of litigation on plaintiffs. Some, Jill said, “end up with litigation neurosis ... and they really can’t see past this actual legal process.” Scully and Jill described the negative impact on plaintiffs who see occupational therapists’ statements that they are “unemployable.” Jill said “to tell them that they are commercially unemployable is not necessarily an accurate reflection of somebody’s residual capacity.” Scully made a similar comment.

Scully: *They start believing that, and that affects other aspects of their lives as well. ... . It becomes harder to get these people back on track and to resolve their claim because to them, all of a sudden this accident has destroyed their life.*

### 5.20.4 Medical Specialists’ Perspectives on Claimants

The medical specialists displayed three discernible attitudes to claimants. The attitudes corresponded to three possible responses of claimants to medico-legal examination when financial rewards are at stake. The responses of claimants were (a) to give an account consistent with medical examination and history, (b) unconscious distortion of a condition and/or its impact influenced by the medico-legal system, and (c) conscious distortion of the condition and/or its impact influenced by the medico-legal system. Matthew was the only medical specialist to identify all three attitudes, with the majority indicating they held the second and/or third attitude. Edmond distinguished further between his perception of the claimants’ responses prompting the second and third attitudes of medical specialists.
Edmond: When a person says they can’t do something and they do do something that’s conscious exaggeration, and when a person due to the secondary manifestations of chronic illness believes they can’t do a thing I believe that is unconscious exaggeration and that is far more common. I think conscious exaggeration is rare - fewer than 5% and they’re bad people!

However during participant verification one unidentified medical specialist responded to this key finding with the response that “malingering is not rare. It is common and often not detected.” With respect to the second and third claimant responses, four medical specialists stated strongly that plaintiffs could consciously or unconsciously misrepresent their conditions, and consequently influence the medical or occupational therapy assessor’s report. Matthew was critical of those occupational therapists who appear to accept the client’s self-report as truth, and in which “there’s no critical scrutiny” of the information.

Matthew: I mean, do you believe everything your patients tell you? I mean, particularly in the medico-legal setting, people need to be aware that plaintiffs bring their own agenda. ... And, I think, part of providing a report is to make that sort of judgement, assessment.

Edmond also perceived some plaintiffs as “manipulating prominent members” of the occupational therapy profession into thinking they are more disabled than they really are. He said that this did “tremendous harm to the occupational therapy profession.” Iamra said that he had learnt from lengthy experience, and from “having been shown surveillance videos,” and so overall his reports for the defendant are now “less sympathetic” towards the claimant as a result of looking at the “cold hard facts.”
He said, “You do have to be a bit calculating.” However, Iamra said that it is difficult to prove when plaintiffs are exaggerating their conditions, even though in one case, “We knew [the complaint] wasn’t true.” He stated that some testing is “entirely dependent on the co-operation of the patient,” and explained the problem of relying on assessment tools alone.

Iamra: You can give the patient something to squeeze. They don’t have to squeeze it as hard as they can. They can squeeze it a bit softer. … And so a lot of the reported specific testing, which looks good on paper, may not be as factual as it appears. I don’t know how you can overcome that.

Four medical specialists believed that plaintiffs were negatively affected either by factors within the medico-legal system or reactions to their injuries. Referring to the literature on whiplash, Iamra said, “So there’s no doubt that litigation prolongs disability.” Peter said, “Most clients are not exaggerating their symptoms but their response may become corrupted in going through the medico-legal process.” Matthew stated, “Some of them may have developed a view about their illness which isn’t substantiated by objective findings.” Two medical specialists, Iamra and Edmond, expressed concern about the impact of litigation on plaintiffs, psychologically as well as physically. They perceived that plaintiffs might not cope with the impact of the injury. Iamra said, “You see some unfortunate people who are obviously quite affected by the accident. And they just go down hill … they ‘lose it.’ ” Edmond said some plaintiffs can develop “A.I.B.” (Abnormal Illness Behaviour). Iamra blamed prolonged rehabilitation and delays in legal settlement for the generation of such “illness behaviour.” He believed that a speedy no-fault settlement “would avoid chronic invalidism and drug addiction in plaintiffs.”
Three medical specialists emphasised that medico-legal experts needed to independently assess plaintiffs and five medical specialists gave examples of avoiding bias while being fair to plaintiffs. Edmond said he accepted referrals from a “white list” of solicitors and barristers who wanted “a middle of the road opinion.” Although Iamra mainly received referrals from the defendant he believed that he is fair to the plaintiff as on occasions his reports lead to more compensation than the plaintiff solicitor initially claimed.

5.21 Summary and Discussion: Participants’ Perspectives on Claimants

Participants identified some demographic characteristics of claimants and attitudes they had to claimants. One key finding was that of the diagnostic groups assessed by occupational therapists the largest is musculoskeletal injuries associated with chronic pain, and the second largest group has cognitive impairment following TBI. Corroborative literature suggests that these reflect the two largest groups of personal injury claimants, with one study from the U.K. indicating that orthopaedic referrals constituted in excess of half of all referrals to medical practitioners, and referrals to neurologists and neurosurgeons constituted approximately one-eight of the referrals (Cornes & Aitken, 1992). The inclusion of cognitive impairment assessments possibly reflects that injuries arising from motor vehicle accidents fall under common law compensation. In what appears to be a development not previously mentioned in the literature, a member of each participant group identified that occupational therapists conducted medico-legal assessments of the impact of obesity on a person’s ability to perform a job. This finding raises questions about whether obesity is regarded as a disabling condition, the extent to which obesity impacts on work performance, and the role of occupational therapists in assessing and providing interventions for this group of claimants.
A second key finding was that the three participant groups indicated that occupational therapists are referred claimants whose work capacity is not easily or accurately assessed. The participants’ views suggest that there is a continuum of claimant responses to assessment in the medico-legal system. The three participant groups had at least one member who attitudes were at one end of the continuum, and perceived that claimants’ complaints can be genuine and was sympathetic to them or believed they may be honest about their complaints. Approximately one-third of occupational therapists expressed this attitude. However, a second and larger group of participants believed that the claimants’ views of their own capacities can not be fully accepted in the medico-legal system and so should be independently and critically assessed by expert witnesses. The veracity of plaintiffs’ reports is a common concern for medical specialists and occupational therapists conducting medico-legal assessments because of the potential for secondary financial gain. Medical specialists’ identified three possible responses of claimants to assessment in the medico-legal system. These responses were: (a) an account that was consistent with the assessed medical condition; (b) unconscious distortion of a condition or its impact, influenced by the medico-legal system; and (c) conscious distortion of the condition or its impact, influenced by the medico-legal system. Several occupational therapists and medical specialists believed that the majority of claimants had the second or third responses. Despite these potential claimant responses, most participants said they do not use the term “malingering” and one medical specialist’s view was that it occurred in less than 5% of cases, although this view was challenged by another medical specialist during participant verification of findings. Claimants who malinger represent the other extreme of the continuum of claimant responses from those that are genuine.

In addition, each participant group had members who perceived that the medico-legal system impacts negatively and irreversibly on claimants to reduce their
assessed work capacity over time. These philosophical stances and beliefs about the
claimant may also reflect the adversarial nature of the medico-legal system. An
adversarial system has contradictory incentives for claimants to be rehabilitated or to
accentuate disability, pain and suffering (O’Donnell, 2000; Schultz et al., 2000).

The literature on assessment in the medico-legal system frequently refers to
malingering, secondary gain and sincerity of effort in relation to claimants (Blau, 1998;
Edwards, 2000). Other sources suggest that malingering in plaintiffs is rare and needs
extended periods of observation of daily activities to reliably detect (Frank, 1997).
Mark (2001) stated that it was imperative that more attention be given to the plaintiff
and his/her needs and less to the adversarial stance of the legal profession and the
insurance industry.

While the literature suggested that diverse perspectives co-exist in the medico-
legal context, for the first time the attitudes of three participant groups to claimants has
been systematically analysed and documented. Based on the findings of the present
research, occupational therapists need to consider claimants’ responses in the medico-
legal system in relation to the continuum of responses when forming opinions for
medico-legal purposes.

5.22 Conclusion: Understanding the Medico-legal System and Interactions with
Stakeholders

In this chapter, participants identified the features of the medico-legal system
that are relevant to occupational therapy opinions on work capacity. Occupational
therapy experts in work capacity need to understand the context in which they provide
medico-legal expert opinions on work capacity and the significance of interactions with
key stakeholders. Their interactions include the written and verbal communications
including attendance at court, briefings, exchange of reports, negotiations and feedback
that changes future interactions. It is within this context that occupational therapists engage in the role of expert witnesses on work capacity in the medico-legal system. In the next chapter, Chapter 6, a set of emerging criteria for identifying occupational therapists’ areas of expertise in work capacity that assist the courts are examined in detail.
6.0 Introduction

This chapter will present the core category of research data, that is, it will include the category to which all other categories were related during data analysis. During data analysis, the basic social problem was identified as the medico-legal system’s need to deal fairly and economically with claimants with a personal injury claim. The basic social process driving participants’ actions to resolve this problem was identified as the medico-legal system’s use of occupational therapy experts on work capacity to assist in making decisions about rehabilitation, compensation, economic loss and employment discrimination in relation to claimants.

In this chapter, the criteria for occupational therapy expert opinions on work capacity that assist in the medico-legal system and specifically in the courts will be presented. The chapter will be structured according these criteria, namely, (a) providing valued expert opinions, (b) identifying occupational therapists’ areas of expertise regarding work capacity, and (c) providing credible and unbiased opinions on work capacity. From findings presented in this chapter a set of theoretical formulations about occupational therapists’ areas of expertise that assist the courts were developed (see Chapter 9).
Providing Valued Occupational Therapy Expert Opinions

In this section, the value of occupational therapists’ contribution as expert witnesses on work capacity will be addressed. The first sub-section, the contribution of “pioneers,” will show how occupational therapists have over the last few decades assisted the courts by providing opinions about claimants with injuries or disabilities. The second sub-section will include participants’ perceptions of the value of occupational therapists’ current contribution.

6.1 The Contribution of “Pioneers”

Occupational therapy participants indicated that the contribution of medico-legal occupational therapists began in Australia in the 1980s and in Canada in the mid-1970s. By the early 1990s, both Barbara and Jennifer considered the occupational therapy medico-legal specialty was well established. Barbara said, “It really has developed and grown and we have, I think, a cadre of OTs out there doing some excellent work in the medico-legal system.” Jessie said that over the years solicitors and barristers “have become more aware of the value and worth of getting an OT report.” Madonna and Donald believed the high regard of lawyers for some pioneers has been transferred to them. Donald supported his belief with a courtroom example.

Donald: I don’t have to be examined on whether I am [an expert]. And the only time … someone made some snide comment at cross-examination about whether or not I was an expert in that area, the judge quite firmly put them in their place and said, ‘Occupational therapists are very much experts in the discussion of employability or job placement.’
Two medical specialists verified that occupational therapists were contributing medico-legal reports to courts in Queensland and New South Wales in the early 1980s. Initially their reports addressed overall function in ADL, and work capacity was mentioned in a general way unrelated to specific jobs. Four medical specialists confirmed that occupational therapists’ medico-legal reporting evolved from their rehabilitation role. Matthew (M) said medico-legal referrals to medical specialists and occupational therapists were initially for comments on people they had treated, and later for “independent” assessments. Owen (M), however, was familiar with occupational therapists’ contribution to injury prevention including job analysis.

6.2 Current Contribution of Occupational Therapy Experts on Work Capacity

A number of participants commented specifically about the current contribution of occupational therapists to medico-legal decisions about work capacity. While some medico-legal concepts and processes outlined in Chapter 5 are reiterated, it is the value of the occupational therapy contribution that is emphasised in this section.

Ten occupational therapists agreed that with respect to the quantum of a case, they assist the courts to determine the amount of compensation or “reasonable damages” the plaintiff should receive. Four occupational therapists identified that occupational therapists’ particular role is the assessment of claimants’ physical capacities in ambiguous or disputed cases. Ona said occupational therapists “determine whether [claimants] are still able to participate in their employment despite their impairment.” Madonna and Jennifer were also aware of the importance of occupational therapists’ contribution in cases of people with moderately severe injury.

Madonna: *I think that occupational therapists have a really strong and fairly powerful input into the decision making about work capacity, particularly in the*
middle of the range cases where a person’s obviously not totally disabled. .... I have known cases to be adjourned because they couldn’t get an OT report in time. I think that says a lot.

Madonna related the value of occupational therapists’ reports to their “wide ranging” input on “both the physical and psychological functional implications of [the claimant’s] disability” and their focus on function rather than merely the physiological and anatomical consequences of an injury. As a further sign of the value of occupational therapy opinions, James referred to the increasing range of jurisdictions in which they are sought. Although Lucy believed that occupational therapists’ opinions might not be regarded as highly as medical opinions, James and Jessie were more positive. James said it is occupational therapists’ “practical ability to assist in making a determination on a person’s function in relation to job demands” that is appreciated by the courts. He said, “Doctors’ reports now are being challenged in some cases I am aware of.” Jessie had witnessed a similar growth of awareness and appreciation.

Jessie: *I think OT reports are far more valid than the medical [ones] under law. … I think we’re equal now, and in many cases I think our reports are valued more than the medical. I mean, a ‘medical’ is a necessity now, and OT reports, are very rapidly becoming a necessity in any common law action.*

Occupational therapy participants who have practised interstate and overseas stated that increasing numbers of occupational therapists contribute medico-legal opinions in New South Wales, Victoria and Canada. Many in this group are private practitioners who incorporate the medico-legal specialty into a rehabilitation practice, with “*just a handful of therapists*” in Queensland defining their practice primarily as
medico-legal (Rod). In terms of an international contribution, two participants noted that occupational therapists in England, the U.S. and Canada are undertaking a similar role to that of their colleagues in Australia.

Lawyers were also asked about the contribution of occupational therapy work capacity opinions to personal injury cases and their views were consistent with those identified by occupational therapists. Three lawyers, Martin, Paogong and Jill, concurred with occupational therapists that their work capacity opinions are valuable when estimating economic loss in disputed cases. Martin stated that if the parties are “far apart on the big-ticket items, like economic loss or care, ... that will quite often involve an occupational therapist.” Two lawyers emphasised the contribution of occupational therapists to decisions about future economic loss. Martin said, as an expert, “an OT is trying to assist a court to determine what’s happened and what’s likely to happen in the future and what the client is capable of, and to give a professional opinion.” Martin outlined the importance of obtaining independent occupational therapy opinions about claimants’ capacities in the future.

Martin: When looking at economic loss, the court breaks it up into two parts: they look at the period from the date of accident till now, and they look at from now until the end of time. It’s very easy to see what’s occurred in the past and treating OTs can write chapter and verse on that, but seldom do they address in their treatment notes, of course, what the long term future or prognosis is going to be. ... So, ... we have to get someone else who hasn’t been treating the patient along the way.
Sean considered occupational therapists provide “a very important opinion” about a person’s work capacity. He stated, “I think the most useful part is that further step that they take - which is, ‘Where does this person now fit in the community?’”

Four lawyers proposed that occupational therapists supplement medical opinions with broader, more thorough and practical opinions of the impact of claimants’ disabilities, expressed in lay terms. If there is doubt about a claimant’s capacities, the occupational therapist has an important contribution to make, as Scully explained.

Scully: I also find them really useful in cases where we suspect a claimant may be malingering or exaggerating their injuries - having a functional capacity assessment to see exactly whether the OT’s observations are consistent with what the claimant is reporting that they can and can’t do.

However, there were some conflicting views from lawyers about the value of occupational therapists’ contribution. Paogong said occupational therapists’ contribution to economic loss determination is only valuable if they are not biased, state their sources of information and do not go outside their area of expertise. Although Max said occupational therapists are specialists in objective analysis of functional capacity, he believed the courts did not rate their reports highly as they contributed little to decisions about quantifying impairment and prognosis in the way that medical specialists do. Despite these limitations, Max acknowledged the occupational therapy contribution to “a global picture of the person” is valuable as every person “needs to be looked at as a whole, and a judge in making a determination will be cognisant of an OT’s report.” Max perceived occupational therapists’ medico-legal role differently to other legal and medical participants. He viewed their main contribution is in a proactive
rehabilitation role to reduce employers’ costs arising from common law claims, unfair
dismissal cases and anti-discrimination cases.

Whether an occupational therapy report is requested may be influenced by
financial considerations. Martin said that a reason for occupational therapists’
contribution not being sought was if it is uneconomical to have such a thorough
investigation and if a claimant would only get “a peppercorn” after legal costs are
paid. Martin explained that in some court systems the legal costs are not always
awarded to claimants; they pay for their legal costs from their damages settlement. He
explained his point further.

Martin: Now, if you have a claim that might be worth $50,000. If you’re a client
of mine and you’ve got a bit of a sore back and it’s not too bad, it might be
worth $50,000 because of the pain and suffering, you might lose a bit of work. I
can tell you now, I’m not going to go and get an orthopaedic surgeon’s report
and pay $1,000 for that; I’m not going to pay to have an OT go out and have a
look at the workplace and pay her/him to come to court and pay $5000 for that.

Medical specialists commented on the contribution of occupational therapy
opinions to medico-legal decisions about work capacity. Iamra’s experience was that at
least one occupational therapist’s report accompanied each of the medico-legal referrals
he receives. David said an occupational therapy assessment “is virtually always an
integral part ... of complicated, protracted cases” that need rehabilitation and may go
to common law. David described a typical situation in which occupational therapy
opinions are required. Consistent with the views of participants in the other two
professions, this is when the claimants’ capacities are in doubt and need to be
substantiated.
David: [The clients] are in this situation because they’ve claimed disability.
Now, OK, unless the disability is obvious – ‘I’ve lost my arm!!’ - or something like this [laughter]. ... Often it is not, it is just the complaint that ‘I cannot use something’ or ‘It hurts’ or ‘I can’t do it’.

In some situations, medical specialists indicated that occupational therapists’ contribution appears to be valued ahead of some other expert opinions. Owen emphasised the importance given to occupational therapy reports compared with other expert opinions in one Industrial Commission hearing. He said, “But it was the occupational therapy assessment, per se, the report which ultimately was the deciding factor. The others didn’t come up in the Industrial Commission.” Owen said, “In the main, they’re very, very good. Certainly, with respect to the majority of these reports, in my limited experience, the judges automatically accept them in the Anti-discrimination Tribunal with significant weighting, yes.”

In contrast, Matthew highlighted some situations where he thought occupational therapists’ opinions in the courts are secondary to those of medical specialists. In other situations they are considered superfluous if the medical assessment adequately addresses the issue of whether a person can work. Yet, Matthew said, “more and more the courts are taking notice [of occupational therapy reports]. I think there probably still needs to be a bit of education about who’s who and exactly what they do and what they can do.” In particular, he said, some lawyers would benefit from knowing when to request occupational therapy opinions.

Contrary to the generally positive views of Owen and Matthew, Edmond stated, “I have to tell you that the occupational therapy reports are not regarded equally with other reports.” Edmond suggested the courts might regard some occupational therapists as “soft” in the same way they had developed a view of some medical
specialists who regularly provide opinions for the courts. In certain cases the courts might not accept the opinions of these “soft” medical specialists. Edmond, David and Iamra all said occupational therapists opinions tend to be too “soft” on the clients. Iamra said he attributed this to the majority of reports being “generated” by the plaintiffs’ solicitors. Edmond and Iamra suggested changes are required just as some medical specialists had gradually developed tougher attitudes to claimants with chronic pain associated with personal injuries. Iamra said he queried the extent of “life experience” of professionals who took “somebody at their face value. ... That’s just not the way things are out there in the world.”

6.3 Summary and Discussion: The Value of Occupational Therapists’ Contribution to Medico-legal Decisions about Work Capacity

Participants highlighted that occupational therapists have been contributing to medico-legal decisions about work capacity for the past three decades. Initially, occupational therapists assisted the courts as treating rehabilitation therapists providing reports on general function in ADL including work, and later as independent experts more directly addressing work capacity. This finding is consistent with literature from Canada, the U.S. and the U.K. (DeMaio-Feldman, 1987; L. Kennedy, 1997a; Sterry, 1998). Another finding is that increasing numbers of occupational therapists are contributing to work capacity decisions, principally as private practitioners. This finding supports overseas literature concerning the growth of occupational therapy consultancies, such as the medico-legal speciality within private practices (Craik & McKay, 2003; DeMaio-Feldman, 1987; Dudgeon & Greenberg, 1998; Harris et al., 1994; Pratt, 1996; Reineke Lyth, 2000; Shriver, 1985). The participants’ indicators of the numbers of occupational therapists involved in medico-legal work are consistent with the indicators from AIHW (1998), and Occupational Therapy Australia -
Queensland (2001b). Together with the literature, the present findings suggest that a substantial minority of occupational therapists who provide work-related services undertake medico-legal assessments, while for a very small number medico-legal consultancy is the primary or sole focus of their practice.

The principal findings in this section are the areas of occupational therapists’ most valued and substantive contribution. The contributions are in assisting the courts to establish the quantum of future economic loss and the payment of reasonable damages in complicated and disputed personal injury cases, including those where malingering or exaggeration is suspected. Occupational therapists provide a holistic and practical assessment of claimants’ residual work capacity including the implications for their participation in work, expressed in lay terms. Their opinions on work capacity generally complement medical reports. Solicitors might not require an occupational therapy report if medical specialists have addressed and quantified the main injuries. This finding is consistent with Canadian research (Hall-Lavoie, 1997) that proposed that medical opinions are sometimes valued ahead of occupational therapy opinions in the courts. The present findings highlight that occupational therapists’ contribution may sometimes be limited by the costs of occupational therapists’ opinions outweighing the benefits for the claimants, perceptions of bias or the reputation of some occupational therapists as having a lenient attitude to the claimants. Lack of life experience may compound a lenient attitude. Interestingly, Berkowitz (1995, p. 243) stated that “rehabilitation is a much softer discipline” than the law and noted that the language and assessments used might not be congruent with the legal context. Beyond that finding, the combined views of the three participant groups in this research have, for the first time, clarified the positive value of occupational therapists’ work capacity opinions in the medico-legal system. They have expressed the value in terms of services assisting the courts. The provision of these services is consistent with a consultancy role.
Identifying Occupational Therapists’ Areas of Expertise

Each participant group identified what they considered to be occupational therapists’ areas of work-related expertise that assist the court. In the first sub-section participants related occupational therapists’ expertise to their professional role, philosophy and conceptual models. In the second sub-section participants compared occupational therapists’ expertise in work capacity with that of other medico-legal experts.

6.4 Occupational Therapists’ Perspectives: Areas of Expertise

In the medico-legal system, it is rare for a request for an occupational therapy expert opinion to have no focus on work, regardless of the claimant’s diagnosis (Barbara, Jennifer, Madonna). Questions often relate to work and other ADL. Accordingly, Madonna assesses work capacity in an estimated 90% of referred cases. She explained how she uses ADL assessments to answer questions about work capacity.

Madonna: *I do the work capacity evaluation and I always do the ADL because I feel that it gives me a lot more information about a person’s capacity to work, if I know how they’re managing and what sort of lifestyle they lead. I do an ADL without a work capacity, but I never do a work capacity without an ADL.*

Work capacity is not considered in the settlement of a minority of cases such as those for retired persons, or persons with “catastrophic” injuries. Rod stated that occupational therapy “*return-to-work opinions and reports would only be relevant in*
[an insurer’s] less catastrophic claims for obvious reasons. A lot of [people with catastrophic injuries] are just unemployable.”

Occupational therapy participants indicated the work-related opinions that solicitors and insurers request from them. These are collated in Table 16.

Table 16
Work-Related Opinions Requested of Occupational Therapists

<table>
<thead>
<tr>
<th>Areas of opinions</th>
<th>Number of OTs identifying the requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Functional physical capacities or residual capacities for return to former job/s</td>
<td>9</td>
</tr>
<tr>
<td>2. The person’s capacity to perform jobs in the future with or without training</td>
<td>7</td>
</tr>
<tr>
<td>3. Advice about the claimant’s employment options (e.g., the person’s chances of employment in the open labour market)</td>
<td>7</td>
</tr>
<tr>
<td>4. The period of the day a person could work, and recommendations to increase the period they work from part-time to full-time</td>
<td>6</td>
</tr>
<tr>
<td>5. A second opinion on an occupational therapy opinion (e.g., the recommendations)</td>
<td>6</td>
</tr>
<tr>
<td>6. The details of suitable jobs matching the claimant’s physical or cognitive capacities</td>
<td>4</td>
</tr>
<tr>
<td>7. An outline of injuries, impact on work and general function, and recommendations</td>
<td>3</td>
</tr>
<tr>
<td>8. The need for and cost of retraining, if a claimant is unable to return to a former job</td>
<td>3</td>
</tr>
</tbody>
</table>

Generally, occupational therapists receive requests for more than one type of assessment and respond in various ways to the requests they received. Their most frequently received requests are to assess claimants’ functional physical capacities for work and for their opinions about the implications for claimants’ employability, that is, the extent of their workforce participation, despite impairment. Six participants used
the term “employability” to refer to the concept of the person’s work capacity meeting the physical demands of present and future jobs in the open labour market. Donald explained how his opinions on employability respond to the referrer’s need for information about claimants’ likely participation in the workforce.

Donald: So the court and the insurers and the solicitors are all interested in the person’s occupational restrictions or abilities, what jobs the person is capable of, how much they will earn doing those jobs, and even if they are capable of them what are the chances of them getting that job in the commercial labour market? .... I mean a person may be physically and vocationally capable of a position but whether an employer will employ them is a very, very different thing.

Donald considered occupational therapists should assess employability using their experiences in occupational and vocational rehabilitation and ergonomics. He said, “I think OTs have such an incredible understanding of work and the physical and psychological demands that it places upon a person. I think they are poised in a unique position to be experts in understanding a person’s employability.” To form an opinion on employability Sophie offers a job analysis, a physical screening and FCE, and a career assessment for unemployed plaintiffs.

When tendering an opinion that claimants need to change their employment, five occupational therapists reported offering a range of suitable alternative jobs commensurate with the claimants’ work experience, education, qualifications, interests, skills and transferable skills. They generally recommend suitable training or education. These five occupational therapists identified vocational resources they used to assist in
making recommendations to increase claimants’ employability (see Table 17). Three occupational therapists reported maintaining current information about training to increase claimants’ employability. Jennifer said that by “cross-referencing and eliminating” catalogued references she matches the claimants’ residual physical capacities to their preferred jobs and the corresponding employment opportunities. Although Bill recognised that insurers might ask occupational therapists for a report on a person’s current functional capacities, he said useful short-term training can be recommended as a solution to the person’s physical limitations.

Table 17
Resources used by Occupational Therapists to Increase Claimants’ Employability

3. Australian Qualification Framework (AQF) (n.d.)
4. Archangel Jobs Market Australia
5. Holland’s Self-directed Search
6. Vocational Interest Survey for Australia (VISA) (Pryor, 1995)
7. Jobs Guide (e.g., from Internet)
8. Employment information in local and state media
10. O*Net (Occupational Information Network, replacing DOT)

Sophie reported that she has assembled a battery of vocational assessments. She summarises jobs of interest to claimants along with the corresponding earning
capacities “at different levels up to the maximum” and the opportunities for employment nationally. Barbara also responded to the claimant’s interests, incorporating them into her reports.

Barbara: She had worked in a paint store. She was carrying heavy gallons of paint in both hands and she ended up with bilateral carpal tunnel problems and she said to me, ‘I really don’t want to continue to do this; this has contributed to my wrist problems. I like management. I’ve already looked at the fact there’s a course at the community college. I would much prefer to do that and I think I could function in a management capacity.’

Eight occupational therapists referred to “function” and “functional capacity” as the basis of their occupational therapy opinions. Jessie was aware that functional capacities do not equate to employment in an open labour market. She said she does not hesitate to say if someone is unemployable, but generally does not recommend alternative jobs. Jessie said, “The essence of OT is a functional approach.” She outlined the way she typically states her opinions on function.

Jessie: [For] a chronic back or chronic pain client, I would say, ‘They may be able to return to work with the following restrictions … and due to the nature of their pain syndrome and the medication they’re on, they would only be able to work on a part-time basis.’ Then you’ve got to look at the reality of them obtaining employment.

Although Antionette said that she receives requests to answer broad questions about employability posed by solicitors, she purposefully limits her responses.
Antionette said, “Essentially a lot of the solicitors need to be educated because most of them just ask, ‘Well, they’ve had an injury, what can they do? What work can they do potentially?’” Rather than emphasise employment options Antionette said her reports answer the questions, ‘What is their functional capacity? What are the functional limitations?’ and so forth, from a physical point of view.” She expands on the course of the claimant’s injury and his/her pre-injury status, basing her recommendations on these findings and referring to other vocational experts.

“Function” appears to have variations in meaning for occupational therapists. Ona interprets function as measuring physical rather than psychological capacity for work, whereas for Sue and John “functional capacity” incorporates physical and psychological capacity. John said, “I am assessing the functional limitations of pain,” suggesting that measures of function assess the impact of impairments. However, Barbara stated it is insufficient for occupational therapists to give an opinion on function; they must give an opinion on “function and occupation,” where “occupation” implies performance of meaningful activities consistent with their role such as worker. With other health care professions claiming a functional focus, Barbara said it is important for occupational therapists to promote “occupational performance” as a unique professional approach with a strong theoretical base for practice and to use the language of the Person-Environment Occupation Performance model, that is, “performance components,” “occupational performance,” and “role competence” (Christiansen & Baum, 1991, 1997).

### 6.4.1 Specialist Occupational Therapy Areas of Expertise

Several occupational therapists, lawyers and medical specialists commented on specialist occupational therapy areas of expertise. Specialist occupational therapists are perceived by themselves and/or others as having more specialised training,
qualifications, or in-depth knowledge, skills and experience of a particular area of expertise compared to their peers, sometimes described by occupational therapy participants as “generalists.” Specialist occupational therapy opinions are also associated with larger settlements. Specialists’ recommendations (e.g., vehicle purchase and modification) can add considerably to compensation costs and, consequently, they attend court in as many as half of their cases.

One occupational therapist employed by an insurer indicated that specialist occupational therapists make an important contribution to medico-legal decisions, and proposed that the professional association accredit specialists so that appropriate medico-legal referrals can more readily be made to them. Subsequently, the researcher, guided by theoretical sampling, recruited five occupational therapy specialist participants with the aim of ascertaining the contribution and areas of expertise of this group. Four of the five specialist occupational therapists reported two compatible areas of expertise (e.g., driving assessment and TBI). The areas of expertise that occupational therapists regard as specialist areas and the number of participants providing services in these areas in the medico-legal system are shown in Table 18.

Table 18
Specialist Areas of Occupational Therapy Expertise

<table>
<thead>
<tr>
<th>Area of expertise</th>
<th>Numbers of occupational therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TBI</td>
<td>9 (7 of whom also provided generalist services)</td>
</tr>
<tr>
<td>2. Driving assessment</td>
<td>3 (2 of whom also provided generalist services)</td>
</tr>
<tr>
<td>3. Spinal cord injury</td>
<td>2</td>
</tr>
<tr>
<td>4. Hand therapy</td>
<td>1</td>
</tr>
</tbody>
</table>
However, with reference to Table 18, the distinction between the areas of expertise of specialists’ and generalists’ opinions is not always clear. The hand therapist was the only occupational therapist to provide only one specialist service. Three of the five occupational therapists recruited as specialists also undertook medico-legal consultation for a wider range of claimant conditions, and some generalist occupational therapists identified that they provided some specialist services. Half of the occupational therapy sample had undertaken cognitive assessments for claimants with TBI in the medico-legal system.

Some participants identified the need for occupational therapists to refer to their specialist occupational therapy colleagues. Three occupational therapists suggested some generalist occupational therapists might lack detailed knowledge of successful return-to-work strategies for a particular client group. In John’s experience, some generalist occupational therapists do not answer specialised questions about driving adequately and might be “unqualified to do so.” He noted that occupational therapists with specialist training are approved to conduct “Fitness to Drive” assessments by some state driving licensing authorities (Ausroads, 2003). John and Rod believed specialist occupational therapists are more likely to return people with injuries to work than those who are not specialised, as they are more skilled in work-related interventions for their client groups. Rod shared his experience.

Rod: *Time and time again we see the medico-legal reports on people with minor to moderate head injuries which say that they’re unemployable. Whereas if we send them off to vocational providers who are experts in acquired brain injury they will get work, they will find them a job.*
Two occupational therapists indicated further reasons for referring to specialist occupational therapists. Antionette refers to an accredited driving assessor for safety reasons. Jessie said that a reason for referral is that barristers are aware of specialist areas of expertise within occupational therapy and will cross-examine experts about their relevant experience. Among the lawyers were two solicitors who identified the need for specialist occupational therapy opinions for claimants with TBI and spinal cord injury. Two medical specialists said that they were familiar with driving assessments undertaken by occupational therapists.

According to three specialist occupational therapists, some lawyers appear to regard specialist occupational therapists as specialist medical practitioners. Questions about future medical costs, treatment, and future improvements in claimants’ conditions are often directed to Lucy, but she considered these to be outside her area of expertise. Three specialist occupational therapists considered that a second specialist occupational therapy opinion might not be sought for comparison with their opinion and, on occasions, they are instead compared to a medical specialist’s opinion obtained by the opposing side. Without contradicting this perspective, Paogon (L) said that a second occupational therapy opinion was not always needed for comparison if the plaintiff and defendant orthopaedic surgeons and the first occupational therapist agreed on the extent of the injury and work capacity.

6.5 Lawyers’ Perspectives: Occupational Therapy Areas of Expertise

Each of the legal participants commented on occupational therapists’ areas of expertise. According to Sean, Max and Scully, the assessment of function is a fundamental service. However, it is the additional expertise that occupational therapists provide that adds to the value of their opinions (Paogong, Scully, Sean). Paogong said that, provided the judge has not developed his/her own expertise, occupational
therapists “bring in expert knowledge” about what the person can do, the availability of suitable work within the capacity of the person, and what work is “available to a person with that disability to get.” Scully emphasised that she needs to know realistic employment options to use at mediation. Scully said, “It is no good saying that someone, say with a brain injury. ... OK, you’ve done an FCE; he’s physically capable of doing this particular work but may not be able to in other ways.” Similarly, Sean said that lawyers are more interested in the occupational therapists’ opinions about employability than any assessment details. He stated that occupational therapy reports commonly provide this opinion.

Sean: The functional capacity, I know, is probably the pure assessment, but the pure assessment is a little bit valueless - in a vacuum. I mean, a judge is interested in what a person can do. I mean, they can lift 5 kilograms with their right arm for 20 minutes, but that doesn't help them in determining whether they're capable of being a car park attendant or a process worker. And it's really the next step that the occupational therapists offer where I think they have really come to the fore.

Sean said occupational therapists have the skills and the knowledge to “know exactly what it is that the person can do and what they can't do - what they're likely to be able to achieve in the long term, in terms of occupation.” He expanded on this point.

Sean: In a trial, just recently, a well known orthopaedic surgeon who does a lot of medico-legal reports was asked, ‘Could [the plaintiff] do this job, could he do that job?’ And the orthopaedic surgeon said, ‘Look, really that's in the
province of the occupational therapist, that's not for me to say whether he can do these things, because I don't know what those involve.’

Sean gave an example of how an occupational therapist can “translate” an FCE “into what it means in the workforce.” Occupational therapists working in vocational and employment services are perceived as offering credible opinions on this topic.

Sean: And the fact is [the occupational therapist] could say, ‘This person who's been out of work for 5 years, is 35 years old, has got a 20% back disability, is on pain medication, if they came to me, I would find great difficulty in getting this person a job. I can just tell you that statistically.’

Martin and Scully linked the areas of occupational therapy expertise with claimants’ obligation to satisfy certain legal requirements. Under work-related legislation claimants need to mitigate their losses through rehabilitation and job search activities despite pain and job loss. In these cases, Martin said, “It’s then very relevant what an occupational therapist thinks about their capability.”

One lawyer had a slightly different perception of the occupational therapy areas of expertise. Max said he refers to orthopaedic surgeons, occupational physicians and engineers for opinions about functional capacity, employment, and ergonomic problems, respectively. He does not refer to an occupational therapist if he got “a pretty clear picture and guidance” from these experts. Instead, he refers to occupational therapists when there are benefits in their attention to details in FCEs and willingness to assess claimants at the work-site compared to occupational physicians. He values the way that occupational therapists follow up a brief orthopaedic report based on “all of probably 10 or 15 minutes,” with their “hands-on” on-site assessment, and the way
they “get out there, they can see what the employee can do, they put them through their paces.” Max did not associate occupational therapy with opinions about ergonomic matters and he does not want academic literature reviews with reports. He said, “That’s not what I am after.” One lawyer perceived a limitation of occupational therapy areas of expertise. Jill said she has reduced the frequency of her referrals to occupational therapists to the extent that she “rarely refers” to them, as she thinks that FCEs are too transparent and clients can malinger. Consequently, she has increased her referrals to other professions who undertake pen-and-paper based vocational assessments as she believed these are “more subtle and less easy to manipulate.”

6.6 Medical Perspectives: Areas of Occupational Therapy Expertise

Medical specialists generally regarded occupational therapists’ areas of expertise as complementary to their own expertise. Edmond and Iamra said orthopaedic surgeons and occupational therapists assess two separate outcomes of a condition, “impairment” being the domain of the former and “capacity” and “disability” being the domain of the latter. However, Edmond said the courts do not fully appreciate these differences “and this is a major weakness in our legal system … because impairment and disability are separate and the courts will not separate them.” Iamra said occupational therapists’ role will become even clearer in the future.

Iamra: I regard [occupational therapists] as a specialty area in themselves and people who are doing basically what we are all doing - advising the courts. But [OTs are] advising them on disabilities, really, rather than impairment, which is our role. In fact, that’s becoming clearer and clearer. The medical role is not to assess disability. It’s not our role. And where we are asked to now we say ‘No, that’s not our role.’
Medical specialists’ perceived that occupational therapists have four areas of expertise (see Table 19). The verbatim descriptions of medical specialists are given.

Table 19
Medical Specialists’ Perceptions of Occupational Therapy Areas of Expertise

<table>
<thead>
<tr>
<th>OT areas of expertise</th>
<th>Descriptions of occupational therapy expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Current functional capacity</td>
<td>“Objectively measure current function,” “current capacities,” “disability and capacity for various functions”</td>
</tr>
<tr>
<td>2. Job analysis</td>
<td>“Work activities,” “genuine occupational requirements,” “ergonomic problems in a job”</td>
</tr>
<tr>
<td>3. Functional capacity and job match</td>
<td>“Investigating complaints of the effects of injury on a current job,” “fitness for a job,” “ability to perform a particular job,” “match and mismatch between abilities or potential abilities and documented demands of a job”</td>
</tr>
<tr>
<td>4. Rehabilitation consultation on employability</td>
<td>“Advice about recovery,” “return to work and the need to change employment,” “overall appraisal of ability to work.”</td>
</tr>
</tbody>
</table>

Iamra said that for people with injuries such as cervical spine and knee joint, the orthopaedic assessment of impairment is based on the range of movement limited by pain, and the occupational therapist “looks into what restrictions that would then lead to in the activities of daily living, work capacity and so forth.” He said he disagrees with his colleagues who set specific limits on activities, as this is also the domain of occupational therapists. Similarly, Matthew referred to research from the U.S. showing that a group of fire fighters who failed medical assessments differed from a group who
did not meet criteria of a Physical Aptitude Assessment. He concluded, “The things that the doctors looked at and found were different from the things that the physical capacity [assessment] found.” When questioned as to whether the most recent WHO (2001) model explains the differences between occupational therapy and medical assessments, Matthew said, “Probably a bit simple, but not a bad rough approximation,” noting that as an occupational physician he also tends to assess work tasks at times.

Four medical specialists’ comments referred to occupational therapists’ assessments of work capacity, function or abilities. Peter said, “The occupational therapist is able to report on the ability of the person to do things. They are uniquely qualified to do that.” Matthew said that when function is unimpaired occupational therapists’ opinions are of limited value. He supported his statement with the example of people with epilepsy whose work performance is unaltered by their condition. Two medical specialists, Iamra and Matthew, implied that occupational therapists’ assessments of function focus on the present. Iamra said occupational therapists “test” the actual capacities “here and now,” while part of the medical specialists’ role “is looking at the future as well.”

The medical specialists’ identified the limitations of occupational therapists’ expertise. In each case, two medical specialists noted these limitations. They are that occupational therapists are unable to provide opinions on (a) diagnosis including a pre-existing medical condition limiting function, (b) prognosis of an injury, (c) future limitations and ability to continue to work long-term, and (d) assessment of risk of re-injury. This view of some medical specialists that occupational therapists do not give opinions about the claimants’ future limitations and ability to work appeared somewhat inconsistent with the view of other participants that occupational therapists give opinions about future employability. Closer examination of the comments suggest that
when occupational therapists form opinions about future employability they use their knowledge of work demands and how people with injury adapt in order to maintain their employment, rather than opinions on prognosis.

6.7 Summary and Discussion: Occupational Therapists’ Areas of Expertise

All three participant groups addressed occupational therapists’ areas of expertise in work capacity and identified that they encompass claimants’ functional capacities for work, the implications for current and future employability, and strategies to increase employability. Job analyses were acknowledged, especially by medical specialists, as assessments to determine the match between claimants’ functional capacities and the demands of jobs. There was a similar high level of agreement between the three participant groups about these areas of expertise during participant verification. These findings are consistent with the views of DeMaio-Feldman (1987), L. Kennedy (1997a) and Morgan (1999) that occupational therapists contribute work capacity opinions based on analysing and describing jobs and relating this information to past, present and potential jobs for claimants with injuries.

Participants described occupational therapists’ areas of expertise in terms of “function” and “employability.” These terms are readily related to occupational therapy and WHO (2001) interdisciplinary conceptual models. The first term, “function,” had a range of meanings for participants, encompassing physical and psychological function, and the residual impact of impairment. In spite of some differences, the meanings of “function” converge around work-related and other daily living tasks or activities a person can perform despite impairment. Occasionally, occupational therapists used the term “occupational performance” almost synonymously with “function.” This is consistent with a trend in several occupational therapy texts to replace the term “function” with “occupational performance” (Christiansen & Baum, 1997; Moyers,
Participant groups agreed that assessments of function are occupational therapists’ principal area of expertise and the foundation of their expert opinions in the medico-legal system. Medical specialists emphasised the notion of occupational therapists’ expertise in assessing “current function” more than the participating lawyers and occupational therapists.

The second term that participants used to identify an area of occupational therapists’ expertise is “employability” or potential for workforce participation. Several lawyers and occupational therapists emphasised that occupational therapists’ expertise in employability is of greater assistance to the courts than expertise in function alone. Two aspects of employability were identified, the first being current employability and the second being future employability. Generally, occupational therapists specify claimants’ capacity to perform work activities, including the period of time the work tasks can be sustained, and whether full or part-time work in the same or previous jobs is feasible. In addition, in the medico-legal system, they use their knowledge of the impact of injury and disability on performance in different jobs, and how people adapt with and without rehabilitation and training, to give opinions on the future employment outcomes for claimants. Individual occupational therapists’ perspectives differed from lawyers and medical specialists in the extent to which they considered that occupational therapists address questions about current and future employability. Lawyers value occupational therapists’ opinions about claimants’ capacity to perform work tasks and jobs in the present and future so that future economic loss and costs of rehabilitation and retraining can be calculated. Opinions on claimants’ employability ensure that occupational therapists’ opinions are legally useful. Collectively, the lawyers indicated that occupational therapists do this well.

Superficially, some medical specialists disagreed about whether occupational therapists are able to make predictions about longer-term outcomes for claimants.
Closer examination of the medical specialists’ comments suggests agreement that occupational therapists do not give opinions about prognosis. A prognosis is a “prediction of the course and end of a disease, and an estimate of the chance for recovery” (Thomas, 1997, p. 1568). However, occupational therapists are able to use their knowledge of work and functional capacity to give opinions about how claimants’ performance of work tasks (activities) and the ability to adapt will impact on current and future workforce participation. These different perspectives suggest that, in order to predict workforce participation, medical specialists predominantly use impairment-related information, while occupational therapists use the claimants’ performance on work tasks (activities) and their potential to adapt to work demands with or without rehabilitation.

Medical specialists’ generally perceived that occupational therapists’ areas of expertise are complementary to their own. One way medical specialists indicated the complementary nature of the opinions was to say that they report on impairment while occupational therapists report on disability. These terms are compatible with the former WHO International Classification of Impairment, Disability and Handicap (1980) and concepts of disability that incorporate the ability to meet personal, social, and occupational demands and to meet legislative requirements (Dembe, 2000). Further, the acknowledgement by some medical specialists of the complementary opinions of medical specialists and occupational therapists may demonstrate a favourable change in attitude since Cornes and Aitken (1992), a psychologist and medical practitioner respectively, criticised medical practitioners’ personal injury reports. These authors specifically criticised medical practitioners for the low priority they gave to referral to occupational therapists and vocational rehabilitation services, the restrictive limitations on activities that could be performed following injury, the lack of detail in medico-legal
reports about ways to adapt workplaces to people with personal injury, and lack of knowledge of the labour market.

Using data from occupational therapists and solicitors, Hall-Lavoie (1997) found that the scope of occupational therapy work-related services to solicitors included FCEs, work-site visits, and vocational assessment. These services correspond to occupational therapists’ areas of expertise identified in the present research. However, the present findings expand upon the medico-legal and occupational therapy literature by examining the areas of occupational therapy work capacity expertise from the perspectives of participants from three key professional groups. Furthermore, participants identified that occupational therapists’ areas of expertise relate to the terms “function” and “employability.” Assessments of function and employability are compatible with occupational therapists assessing “activities” and providing opinions on “participation” on a continuum of impairments, activities and participation according to the WHO ICF (2001). The findings on occupational therapists’ roles are consistent with occupational therapy literature that indicates that activities and participation are the focus of occupational therapists’ assessment and inventions, and assessment of impairments/performance components can be used to support this information (Law & Baum, 2001). Further, the findings of the present research are consistent with occupational therapy authors (Britnell, 2002; Gibson & Strong, 2003; Law & Baum, 2001; Moyers, 1999; Sandqvist & Henriksson, 2004) who noted parallels between the occupational therapy models and the ICF model (WHO, 2001). In particular, the participants’ terms “function” and “employability” are compatible with concepts of “work performance” and “work participation,” which Sandqvist and Henriksson (2004) proposed after examining several frameworks and models used by occupational therapists.
The literature highlighted the contribution of occupational therapists to advancing interdisciplinary theoretical perspectives on work capacity. The work of Matheson and colleagues (Gaudino, Matheson, & Mael, 2001; Matheson, Gaudino, Mael, & Hesse, 2000; Matheson, Kane, & Rodbard, 2001), Innes and Straker (1998b) and O’Halloran and Innes (2005) provide further models worthy of examination and application to the medico-legal system. In the context of the present findings, the models presented by these authors could assist occupational therapists to further clarify the aspects of function and employability that they assess in the medico-legal system and support their assessments and opinions with conceptual models.

The findings have also highlighted some inconsistencies in the way occupational therapists might address the questions directed to them. Agreement within the profession about their contribution along the “impairment-to-wage loss” disability process (Butler & Park, 2000) is likely to advance the occupational therapy medico-legal specialty by providing a consistent response regarding work capacity. The current study includes an attempt to conceptually clarify medical specialists’ and occupational therapists’ roles in the medico-legal system using an interdisciplinary model applicable in a range of spheres including medicine, rehabilitation and the law.

Occupational therapists identified four areas of specialist medico-legal expertise, namely TBI, spinal cord injury, hand injury and driving. Two lawyers and two medical practitioners referred to the value of one or two of these specialist areas. The reduced recognition of the specialist areas by these participant groups can possibly be attributed to them being less familiar with the services.

Some generalist occupational therapists reported providing some specialist assessments while specialists also conducted a range of assessments, suggesting a blurred division between the two groups of occupational therapists, and consequently, identifying specialist areas of occupational therapist expertise may be complex. Even
so, occupational therapists provided some indicators that specialist expertise in work capacity can improve the employment and compensation settlement outcomes for claimants and insurers, and that these outcomes may result in increased referrals to them. These are the first known findings on areas of specialist occupational therapy expertise in work capacity and attempt to explore the potential complexities of accrediting occupational therapy specialists.

6.8 Comparing Occupational Therapists’ Expertise with that of Other Experts

In identifying the parameters of their expertise, the occupational therapists frequently compared their areas of expertise with those of other personal injury experts. Jennifer said occupational therapists should provide “a unique … and a complementary service. … Our reports are, as I see it, a piece of the whole jig-saw puzzle, an incomplete one without an OT report in most cases.” Some occupational therapists specifically avoided comments outside their “professional boundaries” (Alex). Stan said, “Step outside your field and your report’s not worth a row of beans.”

Consequently, referral to other health, rehabilitation and vocational experts was common. However, so as to avoid assuming that a referral will be accepted, Antionette’s referrals are subject to “medical endorsement,” or qualified with the statement “… if deemed suitable by a qualified physiotherapist.” To identify the parameters of their expertise occupational therapists compared their opinions with those of medical specialists, physiotherapists, psychologists and rehabilitation counsellors.

6.8.1 Comparison with Medical Specialists’ Areas of Expertise

In comparing medical specialists’ areas of expertise with their own, occupational therapists emphasised the differences in their professional training and assessment approaches, and the advantages and disadvantages of the expertise of each
profession with respect to work capacity. Table 20 summarises the main differences in the areas of expertise of each profession.

### Table 20
Comparing Medical Specialists’ and Occupational Therapists’ Areas of Expertise

<table>
<thead>
<tr>
<th>Medical specialists</th>
<th>Occupational therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diagnose</td>
<td>1. Assess impact on function/activities</td>
</tr>
<tr>
<td>2. Assess levels of impairment</td>
<td>2. Determine current work capacity</td>
</tr>
<tr>
<td>3. Use impairment tables</td>
<td>3. Recommend return-to-work strategies</td>
</tr>
<tr>
<td>4. Compare pathology and impairment</td>
<td>4. Compare task demands and work capacity</td>
</tr>
<tr>
<td>5. Give generalised work restrictions</td>
<td>5. Conduct job/task analyses at work-sites</td>
</tr>
<tr>
<td>6. Assess risk of re-injury in future work</td>
<td>6. Are realistic about endurance in work tasks</td>
</tr>
<tr>
<td>7. Give opinions on prognosis and longevity</td>
<td>7. Understand whole jobs, not parts or images</td>
</tr>
</tbody>
</table>

Occupational therapists identified that an advantage of medical specialists’ opinions is their use of the AMA “Guides to the Evaluation of Permanent Impairment” (Cocchiarella & Andersson, 2001). Rod said the use of the AMA guides takes “*a lot of ambiguity*” out of medical specialists’ assessments of residual disability. However, other occupational therapists identified that medical opinions based on impairment ratings have limitations. These limitations are that: (a) percentage impairments overlook individual differences, such as the meaning of injury to the person; (b) impairments do not correlate with function; (c) numbers do not indicate what the person can and cannot do; and (d) impairment measures have low predictive validity for work outcomes. Occupational therapists suggested that the advantages of
occupational therapists’ opinions are that they are based on: (a) direct experience of real jobs; (b) measurement of actual work potential of people with injury; and (c) knowledge of employment outcomes for people with injuries, such as whether they sustain employment. Furthermore, Lucy believed that occupational therapists have more recent knowledge than the semi-retired medical specialists who often provide opinions. On the other hand, occupational therapists recognised limitations of their opinions when compared to medical opinions. These limitations are that occupational therapists: (a) lack training in reading X-Rays, Magnetic Resonance Imaging (MRIs) and Computerised Tomography (CT) scans; (b) are unable to diagnose and assess risks associated with medical conditions; and (c) do not adequately explain the natural or accelerated rate of bone degeneration.

Occupational therapists were conscious of times their opinions differed from medical opinions and believed the courts and their colleagues employed by insurers expect them to defer to the opinions of medical specialists. Barbara had strongly disagreed with one medical opinion that suggested a claimant with occupational overuse syndrome could go back to work wearing splints. Barbara said, “The physician said he couldn't believe that I disagreed with him,” when she had “recommended very strongly that it would be in Workers Comp’s best interests to fund [the claimant] for this very short course and then she would literally be off their books.”

6.8.2 Comparison with Physiotherapists’ Areas of Expertise

Occupational therapists generally reported that FCEs undertaken by physiotherapists are rare in the medico-legal system, because occupational therapists provide more holistic assessments of function in a number of areas of claimants’ lives consistent with medico-legal requirements. However, Jessie stated physiotherapists are being “used increasingly, because of ... the biomechanical nature of the injury. And
physios are becoming more functionally based. They can also provide additional
information on the functional impact of a person’s orthopaedic injury.” To some
participating occupational therapists, the physiotherapists’ focus on function is a threat
to the profession. In this regard, Jennifer made specific reference to the title
“occupational physiotherapists.” Further comparison of physiotherapists’ and
occupational therapists’ expertise based on occupational therapists’ perspectives is
shown in Table 21.

Table 21
Comparison of Physiotherapy and Occupational Therapy Expertise: Occupational
Therapists’ Perspectives

<table>
<thead>
<tr>
<th>Physiotherapists</th>
<th>Occupational Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are experts in biomechanics, joint degeneration,</td>
<td>1. Focus more on work capacity and function than physiotherapists</td>
</tr>
<tr>
<td>lower limb and trunk injuries</td>
<td></td>
</tr>
<tr>
<td>2. Prefer quantitative results such as Blankenship</td>
<td>2. Use more varied assessment</td>
</tr>
<tr>
<td>FCE and Jamar dynamometer</td>
<td>approaches and take a wider variety of factors into account</td>
</tr>
<tr>
<td>3. Use impairment measures such as range of movement,</td>
<td>3. Are more aware of the psychosocial factors impacting on</td>
</tr>
<tr>
<td>manual muscle testing, lumbar motion strength tests</td>
<td>return-to-work outcomes</td>
</tr>
<tr>
<td>4. Do not offer opinions about cognitive impairment</td>
<td>4. Use a task analysis approach</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

208
Only one lawyer, Max, commented on physiotherapists undertaking medico-legal assessments. He likened occupational therapists’ expertise in function with physiotherapists’ expertise in movement. He was familiar with the physiotherapy profession and said he has equal regard for occupational therapists and physiotherapists comments on psychosocial issues such as motivation. None of the medical specialists referred to physiotherapists undertaking medico-legal assessments.

6.8.3 Comparison with Psychologists’ and Rehabilitation Counsellors’ Areas of Expertise

Some occupational therapists compared their expertise to that of neuropsychologists, psychologists or rehabilitation counsellors. Only one comment was made about the differences between reports of neuropsychologists and occupational therapists. The comment was that neuropsychologists’ reports using quantitative measures complement occupational therapy assessments of function at the workplace. Psychologists were mentioned in relation to referrals for assessment of adjustment issues, Intelligence Quotient, and work interests, aptitudes and transferable skills. Antionette referred to other experts such as rehabilitation counsellors and psychologists to use her FCE findings in vocational assessments.

Antionette: *I wouldn’t feel comfortable in saying, ‘This person was a plumber and although these are the physical restrictions they can now do this’ because you also need to assess their intellectual ability, and you also need to evaluate their transferable skills and so forth. I believe that OTs are not formally trained in that area, although I think we could do it, I don’t think we are formally trained so I wouldn’t touch it.*
Eight occupational therapists, some of whom had previously addressed vocational issues in more detail, reported to be currently in practices that refer to or employ rehabilitation or vocational counsellors who undertake vocational assessments. Lucy said she had previously used vocational assessments but was not familiar with the labour market. Sue had previously undertaken a comprehensive assessment starting with the physical screening through to advice about employment options. She said she continues to match the results of the FCE with the physical demands of particular jobs “such as console operator,” but no longer assesses the person’s broader “transferable skills” or interests. James refers to another vocational expert for job redirection but differed from Antionette in his rationale. He said, “That’s in our training and we can do it. We’ve got the skills and abilities to do that.” However, he said it was time consuming and there was plenty of other work to be done.

On the other hand, Donald and Bill were critical of the trend away from occupational therapists utilising their existing competencies in the medico-legal system. Quotes from Donald and Bill illustrate their perspectives.

Donald: The major problem [the organisation] has is ... the OT does the physical [assessment] and the counsellor does an assessment and so you get these two reports. You put them in front of you and you think, ‘Did one read the other’s report?’ ... I had a psychologist the other day who felt that a person could be a dog trainer, a security guard or a something else. But the problem was that the person had had a rotator cuff tear and wasn’t physically capable of any of the jobs that this person was describing. ... My answer to that is why didn’t the OT just do the lot because they’ve already spent an extended time with the person developing rapport in the functional capacity evaluation.
Bill: Sometimes therapists tend to have a bit of recipe - ‘Do a FCE, do a this, do a that,’ without really realising that they have the skills to sit down and talk to the person about their actual skills and transferable skills. Because they do an FCE and down the track it’s still not really providing them with any more information than it would from their experience as an OT.

6.9 Summary and Discussion: Comparison of Professional Expertise

Occupational therapists emphasised the importance of being aware of one’s own areas of expertise and expertise of other professions, and staying within one’s areas of expertise when tending an opinion. They often compared their expertise to that of other experts, principally medical specialists. They are careful to avoid opinions on diagnosis, prognosis and percentage impairment given by medical specialists. Participants supported L. Kennedy’s (1997b) identification of the advantages of occupational therapy opinions based on detailed assessments of each individual person’s capacities and potential jobs when compared to medical opinions based on brief in-rooms assessments.

In contrast to L. Kennedy (1997b) and Shriver (1985), who did not identify shared areas of professional expertise, the occupational therapy participants in this research noted some areas of expertise that occupational therapists potentially share with physiotherapists, psychologists or rehabilitation counsellors. Occupational therapists’ focus on function is the premise on which the profession has sought to differentiate itself from other professions. Yet, the term “function” has been adopted by other professions such as physiotherapy. Apart from this potential similarity, occupational therapists differentiated their view of function from that of
physiotherapists who focus on the impact of injury on functional movement while occupational therapists take a diverse range of factors into account in assessing the impact of physical injuries on the person’s work performance and work participation. Furthermore, occupational therapists identified that they assessed the impact of cognitive and psychosocial dysfunction.

Occupational therapists partially supported the views of L. Kennedy (1997b) and Shriver (1985) that occupational therapists’ performance-based assessments of physical capacity for work have advantages over pen-and-paper tests of rehabilitation counsellors. While some occupational therapists refer to a rehabilitation counsellor or psychologist if a person is unable to return to work, other occupational therapists report on claimants’ employment options based on assessment of functional capacities. Shared expertise between occupational therapists, rehabilitation counsellors and psychologists has grown out of transdisciplinary case management/rehabilitation consultancy in vocational rehabilitation and provision of employment services for the long-term unemployed (O’Halloran, 2002). A participant judge noted that judges can also acquire expertise in claimants’ employability. This research finding suggests that there are some areas of overlapping expertise among professions providing expert opinions including some judges. The finding is consistent with Sleister (2000) who noted that in addition to determining the effects of injury on employability (which she defined as the ability to perform basic functions of jobs in the national economy), vocational experts might complete an assessment of their ability to secure jobs in the national economy based on transferable skills analysis, labour market surveys and wage loss analysis. The same finding is inconsistent with the medico-legal literature that has associated particular expertise with particular professional qualifications (e.g., Allnutt & Chaplow, 2000; Blau, 1998; Freckleton & Selby, 2002; Wingate, 2002), but it is consistent with
the courts giving greater weight and admissibility to opinions of experts who are “more expert” on matters before them (D. Tait, 1999, p. 2).

Providing Credible and Unbiased Occupational Therapy Opinions on Work Capacity

The third and final section of this chapter will address participants’ perceptions and experiences of occupational therapists providing credible and unbiased expert opinions. While occupational therapists focused on the importance of credibility, lawyers focused on the importance of unbiased opinions.

6.10 Credibility

Occupational therapists related the credibility of their expert opinions to work experience, competencies, medico-legal experience, and performance in the courtroom. In particular, they identified strategies to maintain credibility during cross-examination.

6.10.1 Credibility and Work Experience

A CV establishes credibility in the medico-legal system. Apart from educational qualifications, a CV lists relevant work experience such as experience with particular client groups. As a group the occupational therapists had diverse work experiences before undertaking medico-legal assessments. Those who commented on this point said they had between 2 years and 15 years prior work experience. Most participants had occupational or vocational rehabilitation experience with or without rehabilitation case management experience. Previous employers included public or private sector
rehabilitation organisations where FCEs are routinely undertaken. Several participants had hospital or community-based rehabilitation experience. A few occupational therapists had specialised hospital and outpatients’ experience (e.g., pain clinic, spinal cord injury unit, or prescription of electronic technology). This specialised experience had generated requests from solicitors. Occupational therapists had mostly assessed function or independence including ADL, home care needs and/or equipment needs for rehabilitation and for personal injury claims before beginning assessments of work capacity. Occupational therapists nominated their work experience that they believe added to credibility in the medico-legal specialty (see Table 22).

Table 22

<table>
<thead>
<tr>
<th>Work Experience adding to Occupational Therapists’ Credibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Years of work experience in vocational and occupational rehabilitation</td>
</tr>
<tr>
<td>2. Experience in a range of industries and workplaces</td>
</tr>
<tr>
<td>3. Extensive work with diagnostic groups assessed in the medico-legal system</td>
</tr>
<tr>
<td>4. Private practice experience</td>
</tr>
<tr>
<td>5. Previous medico-legal experience</td>
</tr>
<tr>
<td>6. Having a current rehabilitation client workload</td>
</tr>
<tr>
<td>7. Academic experience</td>
</tr>
</tbody>
</table>

Five occupational therapists believed that relevant work experience is essential to credibility. Barbara said that her opinions are not based on anything “scientific” but on her experience. She said, “I’ll say, ‘In my experience I’ve seen cases like this and this has happened and this has been the result.’ That has a powerful weight for
lawyers.” Maree added that work experience gives confidence, as “with experience you’ve reviewed and evaluated your reports. You don’t give your best reports on your first year out. ... You learn through that experience ... and the basis for your decision is broader.” Similarly, Rod said specialist work experience is more important than qualifications in court.

6.10.2 Credibility and Competencies

Sixteen occupational therapists identified specific competencies that serve to increase the profession’s credibility in the medico-legal specialty (see Table 23). Some participants stated that particular combinations of these competencies are unique to occupational therapists.

Table 23
Competencies that Increase the Credibility of Occupational Therapy Experts on Work Capacity

<table>
<thead>
<tr>
<th>Competency area and basis of credibility for occupational therapy experts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Qualifications and Awards</strong></td>
</tr>
<tr>
<td>Occupational therapy degree</td>
</tr>
<tr>
<td>Prizes and academic results (e.g., distinctions)</td>
</tr>
<tr>
<td><strong>2. Knowledge and Skills</strong></td>
</tr>
<tr>
<td>Knowledge of biomechanics, ergonomics, task analysis, and job analysis</td>
</tr>
<tr>
<td>Skills in grading and modifying activities, environments and work practices</td>
</tr>
</tbody>
</table>

(Table 23 continues)
Table 23 (continued).

Competency area and basis of credibility for occupational therapy experts

2. Knowledge and Skills (continued)

Understanding of work capacity, demands of heavy work\(^a\), and work hardening

Understanding of cognitive, psychosocial and communication abilities

Skills in applying change management principles to return-to-work programs

Knowledge of relevant literature and the standing of experts

Knowledge of clinical reasoning (professional reasoning and decision making)

3. Assessment Experience

FCE training\(^a\) and experience in using FCEs

Experience in selecting and justifying work assessment components

Experience in developing assessment checklists

Experience in doing work-site visits and assessments of the work environment

Experience in job analysis/assessing physical demands of work

Training and experience in data collection and analysis\(^a\)

4. Reports

Combining observed function and client’s self-report of function in reports

Supporting an opinion with available evidence\(^a\)

Providing an opinion from one’s area of expertise

\(^a\)Individual participants identified five components that would be useful to emphasise in occupational therapy undergraduate training.
6.10.3 Credibility and Medico-legal Experience

Occupational therapists identified that having previous medico-legal experience added further to their credibility as expert witnesses. Medico-legal experience includes undertaking FCEs and job analyses for both plaintiffs and defendants, and attendance at court. One participant highlighted the growth of pre-work FCEs and work trials to reduce the employer’s liability and how undertaking them adds to medico-legal experience. Participants had gained their medico-legal experience in different ways. Some participants had their reports for public organisations subpoenaed, and were subsequently called as expert witnesses. Sophie said that when she began work with a private practice, “as part of normal work you do functional capacity evaluations to answer questions that solicitors have put to you.” Although Stan said that he had “never even chased” medico-legal referrals to his practice, referrals had followed recommendations from occupational therapists and solicitors.

Some participants indicated the numbers of reports they had completed and the percentage going to trial. For example, in an established medico-legal and rehabilitation practice, Sue estimated that she had completed on average three work capacity reports per week for 3½ years and had been to court four times in relation to those reports, that is, less than 5% had gone to trial. The majority of occupational therapists’ experiences reflected the trend towards out-of-court settlement through mediation and conciliation.

Several occupational therapists had gained valued preparation for the medico-legal specialty since graduation. Three main learning opportunities were identified, namely, (a) on-the-job learning, (b) short continuing education courses, and (c) post-graduate education. Professional development strategies are combined with strategies recommended for enhancing expertise in Chapter 8.
6.10.4 Credibility and Courtroom Performance

Occupational therapists frequently related their credibility to courtroom performance, particularly their ability to meet challenges to their credibility. Two occupational therapists distinguished between professional and personal credibility. Ona reported that a barrister “did try to discredit me as a witness,” but that this was directed at her profession, rather than at her personally. Alex had had a similar courtroom experience, but said he found “the judge was defending my position - as an OT.” Elsewhere (see sections 5.8.1 and 5.9), the professional and personal characteristics of occupational therapists that add to credibility in court are identified.

Five occupational therapists who had expected their credibility to be challenged in court had found that it had not been to the extent they anticipated. Donald could recall only one occasion when his credibility was questioned to some extent. He said once an expert witness’s credibility was established it might be too late for the court to “disestablish” it, especially after Supreme Court judges had referred to his/her evidence and “accepted it in full” in a number of decisions. Sue said she had “certainly been warned prior to going in there that solicitors or barristers will try and attack your credibility as much as they can.” She said she had reminded herself that she was the expert “and that the barristers really don’t have a good understanding of what you do and what assessments you use to come to a particular conclusion” and so avoided feeling “too intimidated.”

Three experienced occupational therapists had found that courts did not attempt to discredit them and instead were respectful to occupational therapists. Jennifer said she “heard, from time to time, stories about how people are really demeaned, ... but no, I’ve found utmost respect, and everything I’ve said has been [accepted].” Similarly, Madonna said, “I’ve been grilled intensively by barristers but it has always been respectful.”
Occupational therapists occasionally reported that they or their colleagues had lost some credibility in the courtroom. Madonna said, “There’ve been a couple of exceptions when I really have not been well prepared enough and allowed myself to lose a bit of credibility in court, but that has been the exception rather than the rule.”

6.10.4.1 Credibility and Barristers’ Cross-examination Techniques

Occupational therapists called as expert witnesses identified eleven techniques or tactics that barristers (including QCs/SCs) use in court. Jessie said, “They try lots of tactics. I mean, it’s a situation of tactical thinking about what are they going to do, and how can I best answer this question and what are the holes in my report.” With an understanding of these techniques occupational therapists were able to prepare their courtroom responses.

**Technique 1: Compare occupational therapists’ credibility unfavourably with that of medical specialists.**

Madonna said this comparison is a frequent “barristers’ tactic.” The corresponding response is to reaffirm the occupational therapists’ competencies.

Madonna: The question has been asked ‘Why should we take notice of what you’re saying when Doctor so and so says this?’ and that’s been the gist of the questioning. ‘Isn’t he more skilled than you? You can’t ….’ They’ve said things like ‘Well, he’d have to be more skilled because you can’t diagnose an injury. Those types of questions which I have felt comfortable with countering by outlining OTs’ expertise in work capacity testing and mainly, once again going back to my expertise in that I have returned those people with these injuries to
work before. Or I’ve not been able to return them to work before, whatever the case might be. So, yes, that’s been the implication ‘Well, you’re only a therapist!’ But I regard that comment as a barrister’s ploy. Their job is to make the other people in the courtroom think that what I’ve said is wrong. That’s their job and they need to do that, so I suppose what I am saying to you is - I don’t really believe they thought that at all, but it’s their job to say it.

At times, Ona said this comparison technique included a statement that the medical opinion was more relevant or important to the situation. Sophie has found that disagreement with medical specialists can leave occupational therapists open to questions about credibility.

Sophie: Yes, so in that case my opinion was seen as non-credible ... but ... there had been some video-taped evidence and that really supported what I was saying and that didn’t come out until they were in court. .... So I was sort of stacked against a whole heap of [medical] specialists but then my report plus this video evidence suggested that I was probably closer to the mark.

**Technique 2:** State that an occupational therapist is outside her/his professional expertise.

Donald warned, “*In the medico-legal area you get eaten alive as an OT if you try to offer a diagnosis or even a prognosis for that matter.*” The essential response is to stay within one’s area of expertise in the courtroom and explain the functional basis of occupational therapy opinions. During one cross-examination, Alex recalled being asked, “‘Did my qualifications mean I could actually go over and beyond what the
orthopaedic surgeon was able to recommend?’ So, basically I said, ‘Well, OTs can actually recommend on function so that’s why ….’ ”

**Technique 3: State that the occupational therapist has adopted the medical opinion.**

This technique was used with Barbara and Jessie who were asked whether they had simply agreed with the medical specialist’s opinion. Barbara said she was aware that this would imply her evidence was “null and void.” Barbara’s response was to make “a very strong statement that I am an independent [registered] professional and I make judgements based on my own knowledge and experience and not based on what a medical specialist has to say, unless it’s relevant.”

**Technique 4: Use questions and words in an attempt to confuse the expert witness.**

Barristers often ask long, abstract or technical questions (Sophie), or compound questions containing up to three questions (Madonna). These participants had learnt to handle these questions by asking for the questions to be repeated concisely, and if necessary, reworded in a different way so as to gain extra time and to avoid feeling anxious or overwhelmed. Sophie had another response. Sophie said, “I would basically take my time and write down the question he just asked me and then consider it.”

**Technique 5: Ask the occupational therapist why the person with an injury is unable to do more work.**

Ona had been asked why a person who ran marathons was not fit for his former work. Her response was to analyse the task. Ona said, “I indicated that it wasn’t necessarily a good indication because the job required predominantly heavy lifting that needed upper body strength as opposed to cardiac endurance and lower limb strength.” Shaunagh was asked to compare a claimant’s rehabilitation outcomes with
those of others with the same condition who had achieved more. In her response she highlighted individual differences between the confidence and preferred activities of people with the same condition, rather than their differences in motivation.

Shaunagh: *I remember saying, ‘Well, I’ve seen a person with C4 quadriplegia whilst still an in-patient happily organise himself train transport to get down to the beach for a day out with his mates using a chin-control electric wheelchair and someone else who wouldn’t go without an attendant and went in a cab everywhere. So you can’t really predict [on diagnosis alone].”*

**Technique 6: Produce evidence in court to contradict an occupational therapist’s statement.**

Videos may show plaintiffs as able to do more than the maximum capacity assessed by the occupational therapist. On one occasion when this had occurred, Alex said he replied, “At the time of my assessment I was only privy to that information.” This response is a restatement that one’s opinion is confined to information available at the time of assessment.

**Technique 7: Give scenarios in an attempt to get an occupational therapist to modify an opinion about a plaintiff with chronic pain.**

Acceptance of a scenario may lead logically to a change of opinion. Jessie’s response involved separating a person’s work capacity after rehabilitation from their likelihood of obtaining a job, while Madonna’s response was to not accept the scenario.

Jessie: *They’ll put a scenario to you and say, ‘Well, if we got all these inputs for this lady, couldn’t she go back to work, say, on a part-time basis?’... And you*
say, ‘Well, yes, perhaps she could, but only if those things were in place and then you’ve got to look at the employment of people with chronic injuries. But, in my experience, 20 years of practice, people with chronic injuries do not get employment because they’re a WorkCover risk.’

Madonna: The other tactic they use is to ask you to accept something and then tack a question on it. For instance, ‘So if I can ask you to accept that Joe Bloggs doesn’t have any pain would he be able to work?’ ... That is when I really need time to think because obviously I am not going to be able to justify what I’ve said if I accept that the person’s got no pain. So it’s really, in a way, refusing to answer the question so I would say, ‘I can’t answer that. He has got pain so I can’t accept what you’re saying.’ Some things you can accept.

**Technique 8:** Ask the occupational therapist to justify that the recommendations or conclusions are reasonable, if they differ from those of another occupational therapist.

Jessie said she had learnt to substantiate her recommendations in a clear, logical way within the report so as to have an easier cross-examination. She said, “So the more information and substantiation I put into the report, the less cross [examination] I’m going to get.”

**Technique 9:** Criticise a non-standardised assessment format.

To counter this criticism, Madonna agreed in court that non-standardised assessments had limitations but explained her processes for checking for the consistency of claimants’ performance during assessment.
Madonna: *The comments I make are things like, ‘These conclusions are based on clinical observations. They’re not just based on what the person said. They are based on consistency of effort, consistency of interview data, consistency of performance when being tested in a range of situations where the person doesn’t know what they’re being tested for.’*

**Technique 10: Attempt to provoke an emotional response to reduce credibility.**

Once Jennifer and Madonna became aware of this barristers’ technique they were able to recognise their emotional response to sarcasm or the pressure of repetitious questioning, and to regain control. Jennifer’s response was to be “as respectful as I know how to be.” She described one situation.

Jennifer: *I was beginning to get really angry and then suddenly I must have just had this ability to step outside myself, and I realised that is exactly what he was trying to do, to upset me and get me angry and by that method to reduce my credibility.*

**Technique 11: Accuse the occupational therapist that her/his evidence is biased to favour the referrer.**

Sophie had learned to restate her objectivity and credibility in response to this technique. Accepting referrals for both the plaintiff and defendant supported her response.

Sophie: *One of the opening statements of the counsel opposite me was that ‘You have written an assessment for the insurance company and that’s the way your*
opinion has been based.’ So basically [he was] trying to say that I’m not objective.

6.10.5 Lawyers’ Perspectives on Credibility and Expertise

While the issue of “credibility” received considerable attention from occupational therapists, only one legal practitioner used the word “credibility.” However, when four legal practitioners used the terms “expertise” or “reputation,” these appeared to be synonymous with “credibility” (see also Chapter 5 for the occupational therapy areas of expertise that were valued by participants). For example, when Sean was asked if occupational therapists ever needed to prove their credentials in the medico-legal system his reply was, “No, I don’t think so. ... I think the level of expertise and the presentation of the reports over the last 5 years has improved. Maybe in the last 10 years.” Similarly, Scully said, “When we come up against those that we consider to be quite inexperienced, yes, we will challenge their expertise in court.”

6.11 Bias and Credibility

All participant groups recognised the potential for perceptions of bias to detract from the credibility of occupational therapy opinions. Perceptions of bias may result in the whole report being discarded even though there may be “some useful and usable information on that person in that report” (Bill, OT). All lawyers referred to bias and the effect on reputation or credibility. Some were critical of expert witnesses who they perceived as biased. Paogong did not accept the problem of bias was due simply to gullibility. He said some experts are “gullible ... up to the point of dishonesty sometimes.”
As references to the problem of bias are interspersed throughout all the findings, the emphasis in this section is on the sources of potential bias identified by participants from each professional group (see Table 24), and on the strategies that six occupational therapists and one lawyer identified to counteract it (see Table 25).

Four participants, Alex (OT), Jessie (OT), Martin (L), and Edmond (M), explained how bias could occur. Alex (OT) described the pressures on well-intentioned, ethical practitioners. He said that “the plaintiff’s solicitor or the defendant solicitor is going to be paid from that process and they are looking for a particular framed report.” This expectation might influence an opinion for the plaintiff by an increased focus on disability and inability to work rather than a potential for rehabilitation and return to work “to other less skilled areas or less physically demanding jobs.” Fewer educational options might be provided as, Alex said, “it would then appear that there was no necessity to compensate them if they could have this education program and return back to work.” Jessie (OT) spoke of the potential for bias when giving a secondary opinion on a colleague’s report. In these situations, Jessie said occupational therapists must “give an open and honest opinion. If you agree with what the other person’s saying, say you agree with it. If you disagree, you’ve got to say you disagree and the reasons why you disagree and provide an alternative.” Martin, a plaintiff lawyer, considered bias could arise from both sides within the medico-legal system. He advised occupational therapists of the old Chinese proverb, “Whose bread we eat, his song we sing,” a reference to the influence of whoever pays for a report.

Paogong described how judges perceive credibility based on their previous experience of representing plaintiffs and defendants and seeing many occupational therapists’ reports. He outlined the court’s response to both fair and biased opinions.
Paogong: I mean if the occupational therapist said, ‘Yes, this man does have a serious disability and he will be disabled for a lot of employment, however I feel that he could be able to work within this range of employment.’ ... Most counsel will not be hostile if it’s a fair rendering. You only get the hostility if they feel there has been unfair advice from the experts. So, the best protection for expert witnesses is to get in first and be plainly fair. Manifestly fair!

Table 24
Perceived Sources of Bias Influencing Occupational Therapy Opinions

<table>
<thead>
<tr>
<th>Sources of bias in the medico-legal system</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OT</td>
</tr>
<tr>
<td>1. Payment by referrer</td>
<td>4</td>
</tr>
<tr>
<td>2. Inherent pressures from both sides in an adversarial system</td>
<td>2</td>
</tr>
<tr>
<td>3. A mistaken belief that experts must promote the referrer’s side</td>
<td>2</td>
</tr>
<tr>
<td>4. A focus on disability rather than ability</td>
<td>2</td>
</tr>
<tr>
<td>5. Occupational therapy’s client-centred philosophy</td>
<td>1</td>
</tr>
</tbody>
</table>

Six occupational therapists, aware of the negative effects of bias, had found ways to counteract it. Along with one lawyer, each suggested one or more strategies to reduce perceptions of bias and increase objectivity in reports (see Table 25).
Table 25
Strategies to Reduce Perceptions of Bias in Occupational Therapy Opinions

<table>
<thead>
<tr>
<th>Strategies to reduce perceptions of bias</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write as if there is an opposing expert opinion in a courtroom</td>
<td>3</td>
</tr>
<tr>
<td>Make recommendations in the long-term interests of the claimant</td>
<td>-</td>
</tr>
<tr>
<td>Limit an opinion to what was observed during assessment</td>
<td>2</td>
</tr>
<tr>
<td>Remember your opinion is to assist the court</td>
<td>-</td>
</tr>
<tr>
<td>Accept referrals from both plaintiff and defendant sides</td>
<td>1</td>
</tr>
<tr>
<td>Make return-to-work recommendations as if treating the claimant</td>
<td>-</td>
</tr>
<tr>
<td>Balance optimism and pessimism about the claimant’s future</td>
<td>1</td>
</tr>
<tr>
<td>Avoid stating your opinion as a fact</td>
<td>-</td>
</tr>
<tr>
<td>Give an opinion from the stance of your profession</td>
<td>-</td>
</tr>
<tr>
<td>Avoid an advocacy role</td>
<td>1</td>
</tr>
<tr>
<td>Test the claims of the claimant rather than accept them as true</td>
<td>-</td>
</tr>
<tr>
<td>Give a full account of favourable and unfavourable facts</td>
<td>-</td>
</tr>
</tbody>
</table>

6.12 Summary and Discussion: Providing Credible and Unbiased Occupational Therapy Opinions

These findings indicate that credibility is an important issue for occupational therapists who provide expert opinions. For occupational therapists, providing credible opinions means having them respected by the courts. Occupational therapists related their credibility to prior work experience, medico-legal experience, relevant competencies, and courtroom performance, especially being able to withstand the
challenges of courtroom cross-examination. Eleven courtroom techniques used by barristers to reduce credibility were identified along with the corresponding responses used by occupational therapists. Barristers’ techniques during cross-examination appear to have the dual effects of more sharply defining occupational therapy expertise and challenging the profession to improve the quality of opinions they provide as experts. However, occupational therapists may have an ambivalent attitude to barristers, both admiring and feeling intimidated by their behaviour in the courtroom. These findings suggest that perceptions of their hostility during cross-examination are likely to account for some avoidance of the expert witness role by occupational therapists. Although the literature adequately documents the role of cross-examination of experts and some general techniques used (Alcorn, 1997; Breen et al., 1997; Brodsky, 1991; Freckelton & Selby, 2002; McInnes, 1997; M. Perry, 1997; Stern, 1995; Traves, 2001), much of this information is not specific to occupational therapy experts on work capacity. Further, while occupational therapy literature also includes some techniques used in the cross-examination of occupational therapists (Ekelman Ranke, 1997; Shriver, 1989), the information has not previously been related to the credibility of occupational therapy experts on work capacity. Overall, the current study has elucidated the profession-specific strategies and responses used by barristers and occupational therapists respectively.

Valued work experiences include vocational and occupational rehabilitation experience, and specialised professional experience. Participant occupational therapists entered the medico-legal specialty with between 2 and 15 years prior experience. Experience in the medico-legal specialty further increased credibility. Credibility also consists of having a range of competencies (e.g., qualifications, skills and knowledge). These bases of credibility are consistent with occupational therapy expert witnesses being qualified by “knowledge, skill, experience, training or education” (Shriver, 1989,
p. 251), and suggest that in addition to entry-level qualifications and registration some specialised expertise and experience are required.

Some occupational therapists, experienced in their profession and the courtroom, had found they were treated respectfully at trials. Their responses demonstrate the need for occupational therapists to be assertive, strategic and honest when responding to cross-examination about their areas of expertise and the assessments they use. These findings are principally from Australian occupational therapy work capacity experts, and so, add to the published advice of the U.S. occupational therapists (Ekelman Ranke, 1997; Shiver, 1989).

Some legal practitioners affirmed that increased credibility of occupational therapy opinions on work capacity is associated with full and fair reports of the claimants’ capacities, and the expert’s experience. Some lawyers used “expertise” and “reputation” interchangeably with “credibility.” Occupational therapists and legal practitioners were aware of the risk of occupational therapists’ opinions being perceived as biased or favouring the paying referrer, be they the plaintiff or defendant. This is consistent with Sleister (2000) relating bias and payment of fees to challenges to credibility. Some identified the inherent pressures within the medico-legal system to favour one side and a range of strategies that could be used to counteract bias (see sections 8.7, 8.11, 8.11.2 and 8.12 for further recommendations). The medico-legal and occupational therapy literature concurred that accuracy of information is especially important when under oath and subject to cross-examination (Wyrick & Wyrick, 1988). The findings of this research have identified strategies used by occupational therapists to reduce perceptions of bias and increase objectivity. This detailed list of strategies had not been previously documented for occupational therapists.
6.13 Conclusion: Identifying Occupational Therapy Areas of Expertise in Work Capacity that Assist the Courts

This chapter recorded participants’ experiences and perceptions of how occupational therapists meet the challenge of providing valued, credible and unbiased expert opinions on work capacity within their areas of expertise. The distinctive contribution of occupational therapists is the assessment of claimants’ functional capacities, analysis and description of jobs and relating this information to past, present and potential jobs suitable for claimants. This statement was given full unqualified agreement during participant verification.

Some specialist areas of occupational therapy expertise were identified, but there was some blurring between the assessments undertaken by those with generalist and specialist skills. Occupational therapists often compared their contribution with that of medical specialists and, to a lesser extent, other rehabilitation and vocational experts. Occupational therapists related the credibility of their opinions principally to their relevant work and medico-legal experience, and relevant competencies. In the medico-legal system, there are a number of potential sources of bias that may detract from the credibility of occupational therapy expert opinions. Participants, principally occupational therapists, identified strategies to counteract these potential sources of bias.

In the next chapter, Chapter 7, the methods that occupational therapists use to assess, form opinions and report on the work capacity of claimants with injury will be described. The specific methods described in the next chapter complement the focus of the present chapter on areas of expertise.
7.0 Introduction

The previous chapter identified participants’ perceptions and experiences of occupational therapists’ areas of medico-legal expertise in work capacity that assist the courts. The ways that occupational therapists can provide valued, credible, and unbiased expert opinions within their areas of expertise were outlined. This chapter will present participants’ perspectives and experiences of the methods occupational therapists use to develop expert opinions on work capacity. The first of two sections in the chapter will describe these views in terms of (a) standardised marketed assessments, (b) individualised non-standardised assessments, (c) “eclectic” or combined assessments, (d) assessment of psychosocial factors, and (e) other work-related assessments. The second section will relate to participants’ perspectives and experiences of forming and reporting opinions. This latter section will explore professional reasoning and decision-making methods, and the features of better and poorer quality reports.

A number of terms in this chapter are defined in the glossary. These terms include: subjective, objective, standardised assessments, non-standardised assessments, validity, reliability, norm-referenced assessments, criterion-referenced assessments,
function, functional capacity, job analysis and work capacity. In addition, a sample FCE format based on the DOT (1991) is presented in Appendix K.

Work Capacity Assessments

7.1 Overview of Participants’ Perspectives on Work Capacity Assessments

Occupational therapists identified several types of work-related assessments they use in the medico-legal system. These are standardised marketed work-related assessments, non-standardised individualised work-related assessments, “eclectic” or combined assessments, psychosocial assessments, cognitive assessments, job analysis, and pre-work (i.e., pre-placement and pre-employment) assessments/screening. Participants frequently referred to FCEs. FCEs are a group of assessments of a person’s functional physical capacity for work. FCEs can be standardised or non-standardised.

Occupational therapists identified a number of issues in relation to the use of FCEs in the medico-legal system. In the rehabilitation context, Rod (OT) stated that FCEs can be used to (a) gain a treating medical specialist’s support for a return-to-work plan, (b) set realistic goals for a return-to-work plan, and (c) increase the confidence of the injured worker in his/her ability to work. In the medico-legal system, Rod stated that an objective FCE was “valuable to give an accurate picture of what the person’s capabilities are and also the problems that they do experience.” He said the use of FCEs “ensures that the person receives the settlement they’re entitled to, a more accurate compensation figure.” However, Bill (OT) identified that FCEs have limitations in the medico-legal system. Bill said, “I have less and less faith, I think, in the functional capacity evaluation to really predict a person’s ability to work.” He also said FCEs could not be used to assess work demands that were “medically contraindicated,” such as “repetitive bending and heavy lifting.”
Shaunagh (OT) identified two further issues when selecting work capacity assessments. The first issue is how to assess subjective psychosocial issues such as self-reported pain, self-efficacy and motivation. The second issue is the choice of FCE. She had looked for norm-referenced FCEs, but instead has opted for the criterion-referenced assessments.

Shaunagh: If you’re thinking that there is some objective sort of assessment that can look at work capabilities, it doesn’t exist because it just doesn’t take into consideration the actual person. … I’ve looked at other functional capacity evaluations that are out there, and essentially they are all pretty hopeless when you come to reliability and validity.

Some occupational therapists described the work capacity assessment and reporting process for personal injury claimants. A number of expert medical and paramedical opinions usually accompany a referral. Stan said that this preparatory reading could vary from a page of hospital notes to “reams of information” in two lever arch folders. Usually, occupational therapists conduct a pre-assessment screening before conducting the FCE. For Sue, this “physical screen” consists of identifying “any particular conditions that may warrant certain precautions in the assessment” and is “a warm-up” before assessing the physical demands of work. Pain, muscle strength, range of movement, sensation, blood pressure and heart rate are commonly assessed during the physical screening. The reported duration of FCEs ranged from 1½ to 5 hours.

Only two of the legal practitioners, Sean and Max, referred briefly and in a general way to occupational therapists’ assessment methods. As a consequence, there are infrequent comments from legal practitioners in the first section of this chapter.
Sean said, “Generally they put together the medical evidence in conjunction with the client’s complaints. They use that as the platform and give their advice and state their opinion.” Max described how an occupational therapist asked an employee to undertake tasks that “repeated and mirrored those tasks that he would normally perform at work ... walking on uneven surfaces, walking up gradients, negotiating ladders, steps, confined spaces, etc.”

Medical specialists were generally found to be familiar with occupational therapists conducting a range of work-related assessments in the medico-legal system. The assessments they identified included (a) FCEs/Functional Capacity Assessments, (b) workplace assessments with job analyses, (c) work trials, (d) pain assessments, and (e) vocational assessments. However, one medical specialist was only superficially aware of occupational therapy assessments. In regard to “OT testing protocols,” Iamra said, “There’s a lot of testing - and sometimes I don’t even understand what it is.”

7.2 Standardised Marketed Assessments: Occupational Therapy Perspectives

Occupational therapists referred to the use of standardised marketed assessments (hereafter referred to as standardised FCEs). They indicated that two groups of standardised assessments are used: both conducted indoors. The first group consists of standardised FCEs to assess functional physical capacities with the common aim of eliciting a person’s maximum capacities (e.g., lifting, grip strength). In this group of FCEs, the person demonstrates his/her capacities in response to the therapist’s instructions. Several occupational therapy participants referred to standardised FCEs, namely, Isernhagen, Workhab, West, Blankenship, Valpar, Key, and Workability 3. The second group of standardised assessments consists of questionnaires and pen-and-paper tests in which the person identifies his/her perceived functional physical
capacities and limitations rather than demonstrating them. The PACT Spinal Function Sort (Matheson & Matheson, 1989) is in this second category.

Some occupational therapists raised the issue of the extent to which standardised FCEs are used. Antionette said that only five of approximately 40 occupational therapists attending a recent medico-legal forum reported using standardised FCEs. She said that when she first undertook medico-legal assessments, “I had that idea that I just needed to use standardised equipment because if I went to court I needed to justify my existence.” She now believed that occupational therapists should rely more on their skills and experience than on standardised FCEs. Bill, in a different Australian state, had a similar experience, although he suggested that there is some variability between occupational therapists.

Antoinette: I am very strong about it and I will challenge anybody on that point because I think OTs have very unique skills in the area of functional assessments. So, I believe that you need to be strong and confident enough to be able to assess whatever way you feel is appropriate, depending on the injury and other circumstances, but I don’t believe you have to depend on a piece of equipment to give you that. You draw on that to be able to give you some information but you draw on a lot of different models and a lot of different ideas and thoughts and, you know, things that you’ve gone through in the past.

Bill: I don’t think I’ve seen more than a handful of reports that actually said I am using this particular model or type of functional capacity evaluation. I don’t know anyone who ..., maybe a lot of people use Isernhagen’s principles. Key is one functional capacity evaluation that some providers use, and the Blankenship.
Three occupational therapists believed the use of standardised FCEs is favoured by less experienced occupational therapists who are either “not confident in their own skills” (Antionette), or “more focused on using the testing material and not as comfortable with integrating their own experience because it’s limited” (Barbara).

Alex stated that when he was a novice assessor, he confined his comments to standardised FCE findings.

Some participants reported using standardised assessments in a non-standardised way, as indicated by Antionette. Alternatively, they incorporate principles of standardised assessments into individualised non-standardised assessments (e.g., see Sophie’s use of Isernhagen principles in section 7.6).

Antionette: I ask a lot of my colleagues, ‘What do you use? Do you use Valpar? Do you use MTMs [Methods Time Measurement]? ’ ‘No.’ ‘Do you use norms?’ ‘No.’ ‘Well, how do you use it?’ ‘I just get them to do it.’ So, essentially you might utilise the equipment but not necessarily use the standard, the MTMs or the norm-referenced data. I use it in a non-standardised way which, I would say, just from talking to people, 85% to 90% would do that.

7.2.1 Limitations of Standardised FCEs for Assessing Work Capacity

Eleven occupational therapists shared their experiences of the limitations of standardised FCEs for assessing work capacity (see Table 26). Of this group, five participants specifically stated that they had a moderate level of training in standardised FCEs, including formal or informal training in their design and use. The remaining six participants did not indicate their individual levels of training in FCEs.
Table 26
Limitations of Standardised FCEs as Experienced by Occupational Therapists

<table>
<thead>
<tr>
<th>Limitations</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. They have low validity and reliability (e.g., inter-rater reliability)</td>
<td>6</td>
</tr>
<tr>
<td>2. They substitute statistical calculations for professional reasoning</td>
<td></td>
</tr>
<tr>
<td>about physical capacities</td>
<td>4</td>
</tr>
<tr>
<td>3. The results can not be readily extrapolated to work performance in</td>
<td></td>
</tr>
<tr>
<td>an actual work environment</td>
<td>4</td>
</tr>
<tr>
<td>4. Standardised FCEs designed for manual workers with spinal pain</td>
<td>2</td>
</tr>
<tr>
<td>are not well suited to sedentary workers, or people with sensory impairment (e.g., loss of sense of smell)</td>
<td></td>
</tr>
<tr>
<td>5. The data have limited usefulness; “Some of the data, although it’s true data, is not realistic data”</td>
<td>1</td>
</tr>
<tr>
<td>(Madonna)</td>
<td></td>
</tr>
<tr>
<td>6. “There are no standardised assessments for clients [with work-related injuries and personal injury claims]”</td>
<td>1</td>
</tr>
<tr>
<td>(Barbara)</td>
<td></td>
</tr>
<tr>
<td>7. They are wrongly perceived and marketed as “holding up” in court (Ona)</td>
<td>1</td>
</tr>
</tbody>
</table>

Antionette stated that in her practice standardised FCEs lack value. Similarly, Ona, Bill and Barbara said that job analysis and performance on critical tasks at the workplace, used with interviews, and functional and simulated tasks, better assess work capacity. Excerpts from these occupational therapists indicated the limitations they had experienced with standardised FCEs. These limitations centre on validity and evidence to support opinions.
Ona: The other thing was … from the person’s maximum capacities, they would then use tables to determine the frequencies and the weights and the duration a person could lift, based on these equations. My other concern was that there was no evidence in the literature to support these equations being used or being validated. But that still goes on. … Some people using these types of assessments try to present to the court that it is not just their opinion, but that this is what this means. Because a person could do that in assessment tells me that as a fact.

Bill: FCE …, but again it is an assessment done in-rooms and an extrapolation on isometric muscle activity to, often, a functional workplace where you’re using isotonic, isometric and all other sorts of muscle activity. So I would really like to see any research that looks at the validity [of FCEs]. I guess it’s having that evidence base that there’s some validity if someone can lift something in one environment that that extrapolates to them being able to do something in another environment. Some of them seem to have some norms but they’re norms against all the other people who’ve done the test as opposed to being normed against the wider population.

Barbara: So, because quite frankly, the work I’ve done on validity and reliability and functional assessments is so full of holes that I didn’t say, ‘I used the West and I did this and I did that.’ For me, that does not add a huge amount of credibility to what I am doing. It has to be context related.

Non-professional organisations might be impressed by ‘pseudo-scientific’ approaches. There’s unfortunately been the tendency, by the
Most of the occupational therapists’ comments on the limitations of standardised assessments apply to standardised FCEs used to assess whole body function. In contrast, several occupational therapists reported regularly using some types of standardised assessments to assess specific areas of functioning. One type of assessment measures upper limb impairment. The Jamar Dynamometer (Kasch & Nickerson, 2001) assessment of grip strength is the most frequently used standardised assessment of upper limb function. Six occupational therapists reported using the Jamar. One to two occupational therapists reported using each of the following upper limb assessments: (a) a goniometer, to measure range of movement; (b) the Purdue Pegboard (Tiffin, 1968), to measure upper limb dexterity; and (c) the Minnesota Rate of Manipulation (Mueller et al., 1997), to measure upper limb speed, movement patterns and changes in symptomology. Other types of standardised assessments that occupational therapists identified were those measuring psychosocial factors, such as pain and self-efficacy (see sections 7.8-7.11 for further details).

Some participants identified that the use of standardised assessments does not guarantee valid results as the claimant can voluntarily limit his/her effort. Stan stated, “A Jamar is the most useful because I know it measures a force. I guess the thing that’s subjective about it is, are they exercising full force?” Sue also believed that some claimants distort standardised FCE results by “self-limiting,” that is, they say they are ceasing because of pain, or they say they cannot lift any heavier weights.

Despite the limitations of standardised FCEs, outlined by the majority of occupational therapists, Rod and Jennifer believed that the development of a standardised FCE through research is necessary. Rod said the development of a FCE
with established reliability and validity would lead to its increased use. Although most occupational therapists’ comments focussed on the limitations of standardised FCEs in terms of measurement issues, one occupational therapist (Antionette) raised the issue of the cost of standardised FCEs. She stated that she was prepared to spend what was necessary in order to purchase a suitable FCE, but had concluded that they were not good value for her practice that employed six therapists. Later, during the participant verification of the key findings (see Appendices J1-J5), one unidentified occupational therapist added the following comments.

*My perception is that the cost of standardised/commercial FCEs is one reason therapists don’t use them. My understanding from the literature is that there is little research into the reliability, and particularly the validity of standardised FCEs. But so too there is little reliability or validity [data] on non-standardised FCEs, be they done for rehabilitation or medico-legal purposes.*

### 7.3 Standardised Assessments: Medical Specialists’ Perspectives

Like the lawyers, the medical specialists referred minimally to standardised assessments. However, Matthew said he valued standardised assessments and preferred occupational therapists to use them as the name signifies the assessment process to the reader. He believed any problem lies in the interpretation of the information from the standardised assessments rather than the assessments *per se*. Another two medical specialists had encountered difficulties with the actual use of standardised FCEs. Peter referred to FCEs as having “*an innate problem. ... The process may be wrong to begin with.*” In some instances, he questioned the results of a Blankenship standardised FCE as he “*felt that the non-organic signs were exaggerated. ... So occasionally I feel that the FCE results are wrong but that is not common.*” With respect to the use of Valpar 4
to assess upper limb function, Edmond said, “I don’t think whether I can put my hand through a hole and move my hand about has a great bearing on my life!” This statement suggests there is a problem with the practical application of findings from some assessment tasks to daily life and work.

7.4 Non-standardised Assessments: Occupational Therapy Perspectives

Twelve occupational therapists had developed their own individualised non-standardised assessment (hereafter, referred to as non-standardised assessments) and reporting formats for the medico-legal system. Barbara explained how occupational therapists compensate for limitations of standardised FCEs. She said, “[Standardised FCEs] are not always well validated and that, in fact, our contribution usually comes from observation, knowing the occupational tasks and knowing the physiological and musculoskeletal and neurological mechanisms as well.” Madonna preferred to use her own improvised FCE format and non-standardised equipment for assessing lifting capacity and fine motor skills. She said, “I’ve come up with this one that suits me. So I comment on everything that the person does in the test, in each report and I follow the same pro forma for all or almost all of them.”

These non-standardised FCE formats may be individualised according to six factors identified by six occupational therapists. These factors are (a) the claimant, (b) the claimant’s prime occupation, (c) the nature of the injuries and the stage of recovery, (d) the nature of the pain, (e) the needs of the referrer, and (f) the work environment or setting in question. Barbara described how she would try to understand each individual situation before choosing the assessments.
Barbara: *I would literally look at the setting. I would have read an extensive case chart, known the history of this person’s background. I would have crystallised key questions I wanted to ask [the claimants], their tolerance level, what they thought their limitations were. I would then pick and choose.*

Antionette said she measures static and dynamic postures (e.g., reach, maximum and repetitive lifting) using weights, shelves and benches of varying heights. In addition, she creates functional tasks often lacking in standardised FCEs.

Antionette: *If they do have a hand injury, well, to me, it is more important or more useful that I get them to write for 10 minutes. I get them to do a functional task like make a cup of tea, and carry something, and really utilise the hand in a functional way. And I take photos.*

Eight participants reported basing their non-standardised FCE formats on the DOT (United States Department of Labor, Employment and Training Administration, 1991a, 1991b) (see Appendix K for a sample FCE format). More focussed assessments based on the DOT include only the core or critical physical demands of jobs or occupations under consideration. Work capacity recommendations are then based on the DOT job demand categories (i.e., sedentary, light, medium, heavy and very heavy). Some occupational therapists provide examples of suitable jobs for the claimant in relevant DOT categories and present these in clusters according to whether the jobs are skilled, semi-skilled or unskilled.

While non-standardised FCEs based on the DOT are common practice, Jan, Madonna and Sue viewed the use of the DOT categories as a limitation of some
computer programs aiming to match the person’s physical capacities with jobs. Jan said that some computer programs use the DOT as “their main database of information ... and spit out the results saying that the person could do this, this and this.” Jan cautioned occupational therapists about reliance on computer programs that correlated jobs with the person’s abilities based on computer-based screening “because often they’re not fantastic.” Similarly, Madonna said she does not quote the DOT, or its replacement O*Net, because the job descriptions might be inaccurate for jobs in Australia such as service station attendants. Sue and Ona believed the DOT, while useful, lacks predictive validity concerning the work a person can do or his/her endurance throughout the day in that job. On the other hand, Rod believed “the categories are fine but in some reports it is not clearly documented how they got to that category.” Rod had reviewed many FCE reports and complained about the lack of uniform assessment protocols.

Rod: Some assessments they do use consistently, say the MBI [Modified Barthel Index] however when you’re looking at FCEs they could be using a range of tools and assessments and that will vary from provider to provider. And we know that some OTs use no formal measurements when they’re doing an FCE.

Rod said lack of uniform assessment protocols in non-standardised FCE reports lead to perceptions of bias in the medico-legal system. In contrast, Bill believed there is a role for standardised FCEs in rehabilitation but that they do not have such a valuable role in the medico-legal system. Bill said, “In many respects a stalemate had been reached ... people are just doing what they’ve done before because there hasn’t been any further research base, or not [one] that has become practice.” He said research is
needed to change the “status quo.” Bill’s comments regarding the need for occupational therapy research on FCEs added to those aforementioned by Rod and Jennifer.

7.5 Non-Standardised Assessments: Medical Specialists’ Perspectives

Three medical specialists commented briefly on non-standardised assessments. Peter said, “Non-standardised FCE can be acceptable. I have been quite happy with them. Some non-standardised OT reports are good.” Owen was familiar with the Isernhagen FCE but said he was more familiar with occupational therapists’ work capacity assessments that are specific to organisations and occupations and based on “their site inspection of what is required.” Matthew was dissatisfied with the DOT (1991a, 1991b) list of physical demands used as an FCE because it lacks an assessment protocol. He believed that in this respect it is not an adequate FCE. Matthew preferred standardised in-rooms assessments but, of certain situations, he said, “Objective testing either on work simulation tasks or in the workplace are invaluable in being able to demonstrate to all sorts of people whether or not someone is actually able to do it.”

David made no direct reference to assessments used by occupational therapists, but said that he looks for an opinion and does not “take much notice of the mechanics” of the physical capacity assessments used. He added, “I presume they are professional enough to do their assessment and their job.” This comment was consistent with the views of lawyers who made limited comments on occupational therapists’ choice of assessments indicating it is an occupational therapist’s professional decision, and like medical specialists instead commented in-depth on medico-legal reports that they perused.
7.6 Eclectic or Combined Assessments

Several occupational therapists described eclectic or combined assessments that incorporate both standardised and non-standardised assessments, and different types and sources of information. These types and sources of information include observation of work-related performance, objective and subjective sources of information, and assessments at various sites. Participants from the legal and medical professions also referred to some of these eclectic or combined measurement practices (hereafter referred to as eclectic assessments). With respect to eclectic assessments, five occupational therapists described how they combine certain standardised assessments with non-standardised assessments in order to extend and confirm assessment information. Stan said, “They’re part of the jigsaw that you’re trying to put together. ... I am trying to tell a story about the whole picture.” Jennifer had a similar approach.

Jennifer: Well, a mix of those. I do use some of the pain scales and some of those [standardised assessments]. I also observe pain behaviours, grimacing, all of those things. I then also tend to find myself linking the functional capacity and - OK, supposing you are a tennis player or something, you’ve got to have good shoulder range of movement and if the range of movement of your shoulder is very poor, it kind of confirms that you’ve had to give up tennis. So, I guess there is a certain amount of all of those things plus tying it together, cross-referencing.

Of the standardised FCEs, three participants indicated that only the Isernhagen FCE appears to have a level of acceptance because it provides useful guidelines for identifying physical exertion. Sophie said she applies aspects of this FCE model in her comprehensive eclectic assessments of 2½ to 3 hours (see Table 27).
Table 27

Sophie’s Eclectic FCE “based on the Isernhagen model.”

1. Interview based on self-report of ADL, medical history, and cause of injury;
2. Assessment of pain, including the nature of pain using a body map of current symptom sites, and a visual analogue scale with each symptom intensity rated from 0 to 10;
3. A review of the claimant’s work history, work skills, education and vocational training including certificates or tickets;
4. Objective measures such as height and weight, blood pressure and heart rate;
5. Objective measures of the DOT physical demands of work.

Sophie described some specific aspects of her FCEs in more detail. These indicate her techniques for measuring the claimants’ abilities to perform the physiological as well as the biomechanical demands of work activities.

Sophie: *I put on a heart rate monitor at the beginning of the interviews because often I find that with the heart rate if you say to someone ‘I am measuring your heart rate right now,’ their heart rate goes up because of anxiety.*

*I do the actual different things such as squatting, kneeling for repetitive and sustained periods. We do a walk. I have a metre measure so I measure that out and I do the same walk where I can - unless it’s really, really revolting weather. .... We also do stairs as well. I am also at the same time watching their heart rate as well and particularly after stair climbing and the lifting part because I just might want to see what their maximum heart rate is as we go*
through the assessment. I’ll then do the lifting and check their grip strength with the dynamometer and tell them that they’ll be a bit sore tomorrow.

Some participants who favoured standardised assessments acknowledged the need for non-standardised ones in some assessment situations. Rod said “a bit of a mixture” is needed, particularly in rural and remote settings where occupational therapists are limited to the assessments they can carry, hire or borrow. Alex also perceived that two approaches are needed but for a different reason.

Alex: I suppose with medico-legal you actually have to have a standardised assessment so there is some credibility within the court legal structure and also non-standardised [assessments] to pick up that information that standardised assessment wouldn’t pick up.

7.6.1 Observation of Work-related Performance: Participants’ Perspectives

Twelve occupational therapists made positive comments about their use of observation as a work capacity assessment method. Jessie said, “I think one of the major assessment tools that you use in OT is observation.” Sophie said occupational therapy assessments are realistic because “when we assess people we are watching what they’re doing and we can match what they can and can’t do to positions or jobs.” Maree said she observes the social interactions and features of workplaces for clients with TBI. During “observational” assessments Barbara noted posture, weights lifted, and “whether they used excessive trunk rotation or whether they merely compensated by moving their feet.”
James, Bill and Antionette said observation of physical capacity should be given greater priority in forming a professional opinion. Antionette said she and other occupational therapists spend too much time on “the history, injury history, social history” and this does not add value to their reports for solicitors as the information is already in other reports. The time is better spent on observation of those activities. Bill agreed with her.

Bill: *FCEs are just a tool. It really depends on the observational skills and the experience of the person doing the assessment as to how valid and realistic the recommendations are. If they are skilled in looking at the physical side like whether accessory muscles are coming in and therefore that’s why they know the person’s reached their maximum and all those sorts of things as opposed to just saying, ‘Yes, they were able to lift it.’*

According to Barbara and Sophie, documented observations in reports can be used to illustrate the client’s psychosocial functioning as well as physical functioning for the reader. Barbara said, “*I would usually write very, very detailed descriptions so that they could almost see the patient in their mind’s eye.*” She gave an example.

Barbara: *I might say something like, ‘When I asked Mr X about how he felt about being unemployed, his affect changed and he appeared extremely depressed. His body posture demonstrated depression by lowering his head and he didn’t give me eye contact’ and those kinds of things to try and represent how the client looked.*
Standardised assessments can provide an opportunity for observation. James said, “I use some of the Valpar equipment but then again I tend to use it more on an observation level.” Of particular standardised assessments, Alex said, “I was able to really get a good picture of the person’s functional ability and it also gave scores which made it more credible and then I could also back that up by observation, functional observation.” In some medico-legal assessments Rod said “clinical obs.” or observations are essential.

Rod: I also find [observations] really useful in cases where we suspect a claimant may be malingering or exaggerating their injuries - having a functional capacity assessment to see exactly whether the OT’s observations are consistent with what the claimant is reporting that they can and can’t do.

Four occupational therapists commented on their observations of work tasks as providing objective information. Jan implied that her observations of the functional impact of pain and coping are objective as they complement subjective self-report from the person. Similarly, Sue said, “If there were a number of inconsistencies ... I certainly would report my objective observations.” John also consciously observes daily tasks. He said, “We’re really looking at performance in an objective way there.” Later, he appeared undecided when he said, “Whether you could call that objective, I don’t know. You’re just observing.” [Note: The researcher assumed occupational therapy observations to be at the objective end of a subjective-objective continuum and the issue was not explored further with participants. This was consistent with the approach taken in Allen et al. (2004)].

Three lawyers confirmed that occupational therapy observation of work-related tasks is an important assessment technique. Scully and Paogong rely on occupational
therapy observation to assist in identifying the person’s actual abilities and to check the accuracy of claimants’ statements especially in cases of suspected malingering or exaggeration. [Note: Rod (OT) and Scully (L) were interviewed together so jointly addressed this issue with the researcher]. Paogong said occupational therapists should be “looking to see that [what the client reported] is in fact correct.” Max described how essential observation was in one case.

Max: [One occupational therapist] relied upon him saying to her, ‘Oh, yes, I can squat x, I can squat 15 to 20 times before it starts to get uncomfortable and pain.’ We put him in the box, as you do, and said to him, ‘Did she observe you squatting?’ and he said, ‘No. She didn't observe me squatting.’ … I want to tell you that that became a particularly big issue in the case and I must say it helped our case. And our occupational therapist, you see, she tested him and after one he couldn't squat fully for a start and then after 4 to 5 squats he became unstable, reported pain, etc, etc. That's what I want, that's what I need to know as a lawyer.

Three medical specialists stated they also value occupational therapy observations. Peter referred to FCEs as the basis of occupational therapy standardised observations, while Owen noted occupational therapy job analyses are “done by observing several people who held that job over quite a period of time.” Without hesitation, Edmond identified that the value of good occupational therapy work capacity reports is “observed activity, observed versus self-report.” He gave two reasons for claimants being observed by occupational therapists rather than medical specialists: medical specialists have limited time for observation, and it is more professionally appropriate for occupational therapists to do so. Although all participant
groups agreed that occupational therapists typically undertake observation of work-related tasks in the medico-legal system, it is not unique to the profession. Matthew (M) said he did some direct observation at one on-site assessment because “if I wound up in court, I would like to able to say, ‘Yes, I’ve seen it.’”

7.6.2 Objective and Subjective Sources: Occupational Therapists’ and Legal Practitioners’ Perspectives

Participants’ responses indicated that the acceptability of subjective and objective information depends on whether the source is the plaintiff, the occupational therapist, or the participant’s interpretation of these terms. Two occupational therapists stated that objectivity is the standard for medico-legal practice. Jennifer said subjectivity is poor practice because, “It’s a personal opinion, it’s not a professional opinion based on objective evidence.” John equated “subjectivity” to a clinical interpretation without supporting evidence. However, occupational therapists often seek subjective information from the person with an injury. Barbara stated, “I always put heavy value on the employee’s, the client’s, comments because they know their pain and they know their level [of pain], so that’s weighted very heavily for me.” Lucy said subjective information is “extremely [important]. That’s your real key to how they’re coping and really what the problem is.” Lucy stated that without subjective information the meaning of “absolutely identical injuries [for] someone who is a labourer as opposed to someone who is a concert pianist” is lost. However, some occupational therapists expressed caution about gaining subjective information from claimants. Claimants might not volunteer all the activities they could perform, leading to reports based on inaccurate information. Alex said that discussing with claimants that revealing video evidence could be produced in court helps to increase the accuracy of claimants’ self-reported information.
Several occupational therapists emphasised that subjective information should not be the only information on which to base an opinion and, consequently, use various strategies to increase the objectivity of their reports. These strategies include: (a) corroborating the claimant’s information with information from key people, such as the claimant’s medical practitioner, family, and friends; (b) adopting an impersonal manner during assessment; and (c) not asking the solicitor or claimant the anticipated value of the settlement.

The strategy of combining subjective information from the claimant with more objective information from independent sources was reported by seven occupational therapists. Alex noted that the claimant, his/her family and friends are often in agreement. To overcome this tendency, Antionette said she prefers to “observe and confirm” through activities and discussion with the claimant and key people. She said, “I am not saying what [the claimants] are saying is incorrect, but I don’t take it as an ultimate true statement.” Sophie said she listens to the self-report and then verifies it “by what I see in my assessment. I think it’s the combination that gives you a better assessment.”

Defendant lawyers, Max, Scully and Jill, also associated subjectivity with reproducing the claimant’s self report, and lack of objective assessment and interpretation. Contrary to some occupational therapists’ perspectives, Scully said there is a “high degree of subjectivity” in some occupational therapy medico-legal reports. Jill stated that she now infrequently requests occupational therapy reports. She perceived that they contain claimants’ subjective views of their limitations. Her comments suggested that she is confident in determining the genuineness of claimant’s pain and impact on injury.
Jill: In the case of the genuine ones it is not an issue because you can probably assess what this person is or isn’t able to do. In the case where you have some suspicions as to what the plaintiff is capable of doing, I think often they’re quite capable of manipulating the physical tests so that they reflect the result that they ultimately want.

7.6.3 Assessment Sites: Participants’ Perspectives

All participant groups identified similar issues regarding sites at which work tasks and work capacities are assessed. The issues related to the types of sites available, the use of complementary sites, and the advantages and limitations of assessment sites.

There are two broad types of assessment sites. The first type is in-rooms, alternatively titled “in office” or “in vitro” (Owen, M). The second type is out-of-rooms, alternatively titled “in situ” (Stan, OT, Jennifer, OT) or “in vivo” (Owen, M). Out-of-rooms assessment sites include workplaces, homes, roads, and shopping centres. For one claimant, Jessie (OT) had conducted assessments at five sites that included two offices, a car, public transport, and a home. The assessment site might be determined by professional judgement (James, OT), or stipulated by the referring solicitor (Jan, OT).

At times, occupational therapists use both in-rooms and out-of-rooms sites. If both sites are available, an in-rooms assessment is often completed first. Matthew (M) said an assessment might start with a formal FCE and move to “a workplace-based FCE” with the claimant performing work tasks such as “using the whizzer knife.” In contrast, an initial assessment might be completed at the workplace using known weights and assessing only the critical demands of the job before determining the need for a FCE in-rooms (James, OT). The second approach involves a medical assessment or in-rooms FCE following the occupational therapist’s job analysis and/or FCE at the workplace.
Participants regarded information from each site as useful. Jennifer (OT) said she finds out-of-rooms assessments provide her with complementary information to that obtained in-rooms.

Jennifer: *It is really useful at times to take a person to a busy shopping centre and when they say they can’t bear it, if somebody bumps them, ... just observations. Do the things they divulged in the interview marry with the standardised parts? ... So, I’ve got an environment nearby where I can assess on hills and rough ground and crossing roads. Crossing roads is a wonderful way to see if they’ve got limited neck range of movement - turning their whole body. There are lots of these subtle ways of just cross-referencing your observations when you’re with a person for a good 3 hours.*

Medical specialists concurred that information from each site is complementary. Indeed, Owen (M) said he has occasional difficulty correlating information from the “gym or laboratory situation with the actual work that they have performed unless there is a site visit component to it.” When Owen was asked whether the “in vitro” or “in vivo” component is more important, he referred to one matter before the Industrial Commission.

Owen: *Of the OT components? Really, it was 50-50. The work capacity assessment that came first indicated that this man didn’t have any real problems with hard physical work and it was important to go on-site and to see whether the life situation mirrored the in vitro situation, and it did.*

As summarised in Table 28, several participants noted the advantages of assessing claimants in a natural setting, especially a workplace, compared to in-rooms
assessments. Furthermore, video evidence from workplaces, and driving assessments in unpredictable traffic were perceived to provide trustworthy information. John (OT) said, “If a car jumps out in front of them, those people will react appropriately or inappropriately. They can’t fake it!” Stan (OT) predicted that workplace assessments would increase because, although more time consuming, they provide valuable and relevant information.

Table 28
Advantages of Assessing Claimants in their Workplace

<table>
<thead>
<tr>
<th>Advantages of a Workplace Assessment</th>
<th>OT</th>
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<tbody>
<tr>
<td>1. It results in appropriate and justified recommendations</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>2. It results in a trustworthy account of the claimant’s abilities</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3. It helps account for the effect of environment on performance,</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>consistent with occupational therapy and ICF models (WHO, 2001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Claimants might be more relaxed and less conscious of effect on claims</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>5. Opinions based on workplace assessments are more readily formed</td>
<td>1</td>
<td>-</td>
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</tbody>
</table>

Despite the advantages of workplace assessments, five occupational therapists recognised some reasons for many assessments being conducted in-rooms. Access to the workplace might be limited for industrial or organisational reasons, as indicated in Table 29. Donald said he complies with the claimants’ requests when asking them if he can visit their workplace to conduct an assessment. Donald said that “50% say, ‘No problem,’ the other 50% say ‘I don’t think so’ or ‘I haven’t told my boss about this claim’ or ‘I don’t really want you there because I am a bit self conscious’ or something
Additionally, Owen (M) said a limitation of workplace assessments is the inability to schedule and assess the safety implications of unpredictable conditions. One example he gave was a vehicle driver whose knee locked intermittently.

Table 29

Reasons for Limited Access to Workplaces: Occupational Therapists’ Experiences

<table>
<thead>
<tr>
<th>Reason for limited access to workplaces for assessment</th>
<th>Number of OTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To reduce risk of further liability, if claimant has been assessed as unfit or unsafe</td>
<td>3</td>
</tr>
<tr>
<td>2. If the employer is being sued by the claimant</td>
<td>2</td>
</tr>
<tr>
<td>3. If there is no job to assess (e.g., for people who are unemployed)</td>
<td>1</td>
</tr>
<tr>
<td>4. To comply with the claimant’s request</td>
<td>1</td>
</tr>
</tbody>
</table>

Two occupational therapists and one lawyer said it might sometimes be unnecessary to visit the workplace if alternative sources of information are available. Martin (L) also said, “It’s very hard in a work-related accident, to get an occupational therapist onto the employer’s premises.” However, he suggested some alternative sources which included: (a) photos of the workplace, (b) ergonomic reports from engineers, (c) the claimants’ explanations of the work processes or the work environment, (d) treating occupational therapists’ workplace reports, obtained from the insurers’ files under Freedom of Information legislation. Max (L) said the real issue about workplace assessments is that occupational therapists need to conduct “thorough and objective” assessments and show they understand what it is like “on-site.” He said, “We need to satisfy ourselves that they do have that knowledge and not simply asked the employee what he could do in respect to certain things.”
7.7 Summary and Discussion: Work Capacity Assessments

Based on the findings, a number of conclusions can be drawn about occupational therapists’ assessments of work capacity in the medico-legal system. Conclusions relate to: (a) an emphasis on validity rather than reliability of assessment findings; (b) some participants, principally medical specialists and to a lesser extent lawyers, not understanding the limitation of standardised FCEs; (c) occupational therapists combining subjective and objective information; (d) the predominant use of eclectic approaches with more emphasis on qualitative (non-standardised) than quantitative (standardised) approaches to assessment.

The participants in this research referred frequently to the validity of data collection and gave minimal attention to reliability. Thus, it may be concluded that validity is a greater consideration than reliability in this context. One possible explanation for this is that in the medico-legal system reliability is determined by the judiciary or insurers when they compare the opinions of experts for their consistency. Occupational therapists were found to be reluctant to use standardised FCEs as the main source of information in the medico-legal system. The low validity of standardised FCEs, especially predictive validity for measuring work participation, was the main limitation perceived of these FCEs. Participants identified that additional information to that provided by standardised FCEs on work task performance is needed to predict work participation. Some participants said standardised FCEs are wrongly perceived as supplying accurate information for the courts. Standardised FCEs appeared to be utilised by some occupational therapists with less experience on which to base their professional reasoning and decision-making. One medical specialist favoured standardised assessments as the name signified that certain procedures have been followed. In contrast, other medical specialists perceived standardised FCEs have some limitations in design and application to questions posed in the medico-legal system. Overall, however, it may be concluded that an appreciation of the
limitations of standardised FCEs, such as lack of inter-rater reliability, contextual validity and predictive validity, may not extend to medical specialists, insurers and lawyers.

Because of their perceived validity, most occupational therapy participants were found to prefer non-standardised FCEs that they develop and adapt to suit their own purposes and practices. Several occupational therapy participants favoured non-standardised assessments of function based on the DOT (1991) that they individualise to each claimant. Occupational therapists and medical specialists who commented on the DOT were either unaware of or did not refer to the assessment protocol based on the DOT (Fishbain et al., 1994, 1999). However, the DOT classification of jobs according to the physical demands could also present problems in interpretation especially with prediction of employment outcomes (i.e., work participation) for claimants. A small number of participants commented that occupational therapists incorporate Isernhagen principles into non-standardised assessments. Specifically, functional and simulated work tasks are incorporated into these individualised assessments to better assess a person’s work capacity. Non-standardised assessments may be used in conjunction with portable, often paper-based, standardised assessments of hand function, spinal function and psychosocial factors. Notably, several of these portable standardised assessments have acceptable levels of reliability and validity based on self-report and/or performance of the person with injury in the rehabilitation context.

The findings suggest that in their medico-legal assessments, occupational therapists combine objective information from assessments and subjective information from claimants. Participant groups concurred that this increases the validity of assessments and that a lack of balanced information leads to skewed interpretation. Self-report measures are quick, convenient, and inexpensive performance measurements. Yet, past research regarding self-report of people who are healthy and
those with chronic pain suggested that both groups may underestimate their performance, and that self-reports need to be cross-referenced with observation of performance on related tasks (Abdel-Moty et al., 1996).

Observation of work-related performance emerged as a substantive occupational therapy assessment method that is consciously used to gather essential and credible assessment information in the medico-legal system. Non-standardised assessments, standardised assessments and workplace visits were all viewed as creating opportunities for observation. These observations were represented as objective information complementing subjective self-reported information from the claimant. Members of each participant group identified that strategic observation of work-related performance is critical in cases of suspected malingering or exaggeration. Medical specialists and lawyers endorsed the need for accurate and thorough observation of a claimant’s work-related performance. While some participant occupational therapists emphasised the need for objectivity in medico-legal reports and explained their strategies to increase objectivity, defendant lawyer participants perceived that some occupational therapists’ reports lacked objectivity. From these differing views it may be surmised that some occupational therapists’ medico-legal reports lack objectivity. However, a second explanation is that objectivity is defined differently by different professional groups. A third explanation is that, in an adversarial medico-legal system, the stance of the defendant and plaintiff is that the opposing party lacks objectivity, and that this forms the basis of strategies to reduce their credibility. While each of these explanations appear valid to some extent, it can generally be concluded that experts need to support their opinions with objective sources of information.

There was general agreement among participants about the advantages of a job analysis conducted at the workplace for achieving contextual validity. Principally, these advantages are that workplace assessments result in readily justifiable recommendations
and may give a more authentic account of the claimant’s abilities. The findings also support the value of including careful documentation and photographic records in a job analysis. In the medico-legal system, such information from the workplace increases validity. If it is not possible to access the workplace, reports of other professionals who have visited the workplace and the claimant’s account of the work tasks, processes and environment are among alternative sources of information used to simulate the workplace and specific jobs, and to inform professional reasoning and decision making.

Overall, a pattern of “eclectic” assessments emerged as a consistent approach to assessment, whereby occupational therapists synthesize information from a range of assessments to compensate for their limitations and to verify or authenticate their findings. As Matheson (2001) stated, work performance is complex and requires several different types of assessments for several different types of worker attributes. This information collection process is consistent with data collection processes employed in mixed methodology research (Tashakkori & Teddlie, 1998). In the qualitative research component of mixed methodology, an interview to gain insight into the meaning of the individual’s experience is combined with participant observation and triangulated sources and types of information to increase rigour. In the quantitative research component of mixed methodology, objective measurement and standardised assessments are used. These findings are also substantially consistent with the findings of a study by Innes and Straker (2002b) that considered therapy practices for rehabilitation and medico-legal purposes together. These authors identified that occupational therapists and physiotherapists in Australia use qualitative and quantitative information collection methods depending on the assessment site and whether there are jobs identified for consideration. In the current research, occupational therapists were also found to mainly use qualitative information which was supplemented with quantitative information from portable standardised assessments of
function. The inclusion of information from standardised FCE assessment protocols by some occupational therapists appears to be influenced by perceived expectations of other stakeholders in the medico-legal system and assumptions about standardised FCEs, such as those expressed by some lawyers and medical specialists. It is probable that the use of standardised assessments to assess work capacity is also influenced by some literature that identified that using standardised assessments in-rooms is an internationally-accepted rehabilitation practice (Deen et al., 2002; Jundt & King, 1997; Lo, 2000).

In the present study, occupational therapists placed greater emphasis on application of measurement principles than on the use of particular standardised assessments in the medico-legal system. This may be accounted for by the low levels of validity and reliability of FCEs (Innes & Straker, 1999a, 1999b; King et al., 1998) and by the focus of FCEs on functional work demands or activities rather than on work participation (Brintnell, 2002; Gibson & Strong, 2003; Law & Baum, 2001; Sandqvist & Henriksson, 2004; WHO, 2001). In the present research, the findings from standardised FCEs were not regarded by occupational therapists as a valid measure of a person’s capacity to participate in work. They reported supplementing the FCE findings with other assessments, especially with work tasks and simulated work, and using professional reasoning about how the findings apply to future work participation. This type of predictive professional reasoning anticipates future outcomes of therapy (Fleming, 1994; Higgs & Jones, 2000). Using predictive reasoning, occupational therapy experts on work capacity may consider future work participation in terms of the claimant’s unique context, his/her performance of assessed tasks, the presenting condition, responses to rehabilitation, and individual factors such as motivation, and fear of re-injury. Occupational therapists participants indicated that prediction is made
more difficult if they need to extrapolate from a static controlled indoor environment to a complex workplace.

Despite some perceptions that standardised assessments are more credible in the medico-legal environment, the use of an eclectic approach to assessment appears acceptable to the occupational therapy profession. Law and Baum (2001) identified that occupational therapy assessment tools and methods include qualitative and quantitative methods such as “naturalistic observation, interview, rating of task performance and self-report” (p. 14). Furthermore, the conclusions of the current research findings on assessments are that assessment types and sources need to be selected to inform occupational therapists about claimants’ work performance and work participation (Sandqvist & Henriksson, 2004). With reference to Sandqvist and Henriksson’s (2004) framework, a conclusion is that standardised assessments with acceptable reliability and validity appear best suited to measurement of individual capacity such as decreased range of motion (i.e., changes to body structure and function) and work performance such as standing tasks (i.e., work activities or tasks), but appear to be inappropriate for comprehensive assessments of complex situations like work participation (i.e., employability), for which qualitative measures may be better suited.

The present study represents the first known attempt to systematically investigate the ways in which occupational therapists select assessments to identify work capacity in the medico-legal system. The findings highlighted that some occupational therapy, legal and medical participants prefer standardised assessments and that the reasons why experienced occupational therapists select the eclectic assessment approach in the medico-legal system may not be well understood by medico-legal stakeholders. The implications are that the occupational therapy profession needs to support the eclectic assessment approach with their professional reasoning. They need to explain the benefits of using this approach for the stakeholders.
in more detail. For this reason, the relationship between occupational therapy medico-legal assessment practices and occupational therapy conceptual models needs to be made more explicit in interactions with medico-legal stakeholders and other professions.

7.8 Assessing Psychosocial Factors: Occupational Therapists’ Perspectives

Occupational therapy participants were asked about their use of psychosocial assessments and reporting (see Interview Guide in Appendices E and F). Psychosocial factors impacting on work capacity were perceived as legitimate and meaningful components of holistic occupational therapy practice. Bill said, “In my experience in the workplace, ... it’s the actual physical capacities of people that are often the least important things in their returning to work.” Similarly, Sophie said she hesitates to give an opinion on physical capacity alone. Based on the literature, she incorporates psychosocial factors impacting on work capacity into her assessments.

Of the psychosocial factors, the claimant’s pain is most consistently reported. Eleven occupational therapists reported assessing the claimant’s pain and its impact on function. Donald said he includes assessments of a person’s pain, self-efficacy for work, and fear of re-injury that might provide information about low levels of work performance “rather than just labelling them as a malingerer.” Shaunagh said she addresses the person’s work interests to increase the chances of a positive outcome, and likened it to leading “the horse to the water that it wants to drink.” Barbara was critical of one occupational therapist’s report in which she believed there was a lack of appreciation of psychosocial factors affecting work performance. Barbara said, “There was no comment made about the difficulty with language, the emotional component of coming from another country, trying to adjust, and becoming injured. [The reporting therapist] did not ask for an interpreter.” Occupational therapists identified the range
of psychosocial factors they may assess in personal injury proceedings, for the impact on work capacity (see Table 30).

Table 30

Psychosocial Factors Occupational Therapists Assess for the Impact on Work Capacity

<table>
<thead>
<tr>
<th>Psychosocial factors</th>
<th>Number reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pain and its impact on function</td>
<td>11</td>
</tr>
<tr>
<td>2. Work-related factors</td>
<td></td>
</tr>
<tr>
<td>Motivation to return to work</td>
<td>5</td>
</tr>
<tr>
<td>Pre-injury satisfaction with work, and relationship with employer</td>
<td>3</td>
</tr>
<tr>
<td>Motivation for alternative jobs of interest to the claimant</td>
<td>2</td>
</tr>
<tr>
<td>Aptitude for work (e.g., work skills, personal organisation)</td>
<td>2</td>
</tr>
<tr>
<td>Goals for his/her working life</td>
<td>1</td>
</tr>
<tr>
<td>3. Mood or emotional factors</td>
<td></td>
</tr>
<tr>
<td>Depression/anxiety and/or loss of enjoyment of life</td>
<td>6</td>
</tr>
<tr>
<td>Coping strategies (e.g., anger or stress management)</td>
<td>3</td>
</tr>
<tr>
<td>Fear of re-injury</td>
<td>1</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>1</td>
</tr>
<tr>
<td>4. Work-related socio-cultural factors</td>
<td></td>
</tr>
<tr>
<td>Impact on family issues such as parenting role</td>
<td>2</td>
</tr>
<tr>
<td>Social support</td>
<td>2</td>
</tr>
<tr>
<td>Cultural, linguistic and adjustment issues for immigrant workers</td>
<td>1</td>
</tr>
<tr>
<td>5. Factors raised by the judge in court</td>
<td></td>
</tr>
<tr>
<td>Personal qualities (e.g., motivation), coping style, personality</td>
<td>1</td>
</tr>
</tbody>
</table>
The occupational therapists may assess psychosocial factors informally or by using standardised assessments. In addition to unspecified “standardised pain questionnaires” mentioned by two occupational therapists, those used by one or more occupational therapists are: (a) a horizontal visual analogue scale (cited in J. Strong, Sturgess, Unruh, & Vincenzino, 2002); (b) Pain Drawing (Margolis, Tait, & Krause, 1986); (c) Spinal Function Sort (Matheson, 1993; Matheson & Matheson, 1989); (d) Oswestry Low Back Pain Disability Questionnaire (Fairbank, Couper, Davies, & O’Brien, 1980); (e) McGill Pain Questionnaire (Melzack, 1975); (f) Pain Disability Index (R. C. Tait et al., 1987, 1990); and (g) self-efficacy ratings (e.g., Gage, Noh, Polatajko, & Kaspar, 1994). Some participants reported using these formal assessments of pain in the past. In comparison, the current focus of occupational therapists in the medico-legal system appears to be on assessment of the functional impact of psychosocial factors. For example, John said he observes the way a person’s ability to drive safely is affected by pain. If a person has a shoulder injury, he observes the person’s ability to steer properly. John said pain may reduce endurance and concentration, but the person’s coping strategies may mean that they can still drive safely.

7.8.1 Barriers to Occupational Therapy Opinions on Psychosocial Factors

In medico-legal reports, there were several identified barriers to occupational therapists providing opinions on psychosocial factors that they would normally include in rehabilitation reports. Rod (OT) said a holistic psychosocial assessment was professionally appropriate but said, “They just can’t fill up ten pages of a report on pain, and body maps and type of pain, it needs to be balanced with what they can do and what their function is.”
Seven occupational therapists identified reasons for limiting or avoiding opinions on psychosocial factors. The most commonly cited reason was the difficulty supporting statements and judgements made during assessment, especially in court. Additional reasons identified were: (a) the inclusion of psychosocial factors led to a more qualified, but a less succinct opinion, about a person’s work capacity because of the amount of discussion and analysis needed; (b) the difficulty assessing psychosocial factors fully in a 3 to 4 hour medico-legal assessment compared with one undertaken for rehabilitation purposes; (c) a psychologist may have assessed the issue/s prior to referral; and (d) pain and suffering are not considered in many compensation systems.

In court, explaining the relationship between physical and psychosocial factors can be problematic. Three occupational therapists described the problem as justifying comments about the impact of pain on observed activity succinctly and in simple language. Donald gave his reasons for decreasing the formal assessments of claimants’ self-reports of pain.

Donald: *In court you don’t have the vocabulary, you don’t have the time to spend explaining it. Your answers are “Yes/no” or short sentences and anything greater than that often means you are loading a gun to shoot back at you. It is very, very difficult to help the court to understand the value of psychosocial assessment.*

Jan, an experienced therapist, had a different experience in the courtroom. She assessed the impact of psychosocial factors on function, but did not include this in reports.
Jan: Often the court will ask you about the person themselves, the qualities that you’ve observed in the person and the type of person. They can be very interested in your judgement, in your view of that. I think it’s quite appropriate that it comes out in the court and not necessarily in the report. That’s my main experience. They are certainly very interested in the personal information. However, I would be most reluctant to put a lot of that information into the report, necessarily, as an occupational therapist.

7.8.2 Psychosocial Comments and Referral

In view of the barriers to occupational therapists including opinions on psychosocial factors in medico-legal reports, six occupational therapists stated their response is often to limit this type of opinion and refer to counsellors, psychologists or psychiatrists. Even so, Rod cautioned occupational therapists to refer appropriately rather than “providing a specific psychiatric diagnosis” or assuming that a psychiatrist or psychologist will treat the person for a stated number of sessions in a certain way (e.g., with Cognitive Behavioural Therapy). Similarly, Jessie said, “The costs, duration and frequency of this input must be obtained from qualified counsellors.” The indicators for referral were not always clear. James made recommendations for pain management or adjustment-to-injury counselling to counsellors but had referred a claimant with anxiety to another occupational therapist. Madonna said that she reports briefly on some psychosocial factors impacting on the physical work capacity, but is careful not to portray herself as an expert. She said, “I keep my comments fairly practical. Most of the time psychological symptoms really affect people in functional ways. There’s not much to argue with.” Maree was aware of the challenge for
occupational therapists who wanted to give a more extensive opinion on the psychosocial factors for a claimant.

Maree: *I want to look on a much broader level at people’s psychosocial needs and personal needs and background and experience. And it’s difficult to restrain that in some ways but it is necessary to restrain that because otherwise I don’t think we’re offering an opinion about what we say we are offering an opinion about.*

Jessie suggested that before commenting on a topic, including psychosocial factors, occupational therapists should consider their expertise. She said that ultimately the most important justification for an occupational therapist’s opinion on a topic is her/his qualifications, experience and confidence.

7.9 Psychosocial Factors: Legal Practitioners’ Perspectives

Like the other two professional groups, lawyers were asked about any psychosocial assessments occupational therapists undertook as part of the assessment of functional capacities for work. Scully stated that it is useful to obtain from occupational therapists’ reports such personal information as, “*Do they have children? What is their past work experience? What is their occupational history?*”

Consistent with the occupational therapists, the legal practitioners recognised that pain is commonly an issue for personal injury claimants. Max and Scully welcomed comments on pain, though not necessarily from occupational therapists exclusively, and suggested they defer their opinions to psychiatry or psychology experts regarding the effect of chronic pain on the person's motivation, and likely recovery time. Scully stated that it is important that occupational therapists look at
more than the history of pain by using their observational skills and interpreting what they see. She cautioned occupational therapists against making recommendations “not in their field of expertise.” She declared, “I have OT reports where the occupational therapist has diagnosed depression and recommended 10 psychiatric treatments at this cost!” Paogong said occupational therapists should avoid duplicating the medical assessment. He, like Sean and Scully, considered they should focus on the impact of psychosocial factors on the person’s capacity to work.

On the other hand, Jill noted that while some occupational therapists assess pain, most confine their comments to the impact on work capacity. However, she said she was sceptical about the value of assessments of pain in medico-legal reports. Her doubts about reports on pain are that: (a) they were based on a claimant’s self-report that are impossible to substantiate, and difficult to measure; (b) pain experience is complicated by dependence on “opiate-type drugs;” (c) “the plaintiffs’ solicitors don’t appear to plea that this condition has produced a psychological reaction, rather than a physical one;” and (d) occupational therapists are likely to say that a person can not work because of pain. She made additional points about pain assessments.

Jill: I have seen people fudge those tests. They get on there and they gasp and they Huff and they puff and they sit in this chair and they’ll get up. You know, it is not hard to do if you are of that mind. I don’t know how experts overcome those things but I guess if somebody’s paying you $1,500 or $2,000 for a report you are not going to say, ‘Well, I think your client’s a liar.’

In comparison, Sean’s experience of serious cases “above $250,000” in the Supreme Court is that occupational therapists do comment on psychosocial factors apart from pain. He reinforced “their primary function” is to comment on physical
capacity, however, their comments may include the negative impact of disturbances of mood such as depression on the likelihood of a person obtaining a job.

Sean:  *So, for example, your 55 year-old female who becomes a single amputee and had previously worked in process work, and has lost her non-dominant arm and had a major depressive episode. Most occupational therapists would submit that looking at her on a purely functional level, yes, she probably still can put tops on lids or operate a machine. But from a global view of her psychosocial and physical function, and looking at her in the context of the commercial marketplace, she's never going to get a job. She's got no hope.*

Sean outlined his experience of occupational therapists staying within their area of expertise with respect to psychosocial factors. He stated that occupational therapists usually report the claimant’s statements about the psychosocial impact of an injury and accept the psychological and psychiatric assessments. They will add to diagnoses, such as severe Post-Traumatic Stress Disorder or Agoraphobia, the impact on work if a person is unable to leave the house. Martin also welcomed relevant psychosocial comment by occupational therapists, stating that all relevant information should contribute to a just decision. Martin said, “*And there will always be arguments over relevance, the ability to give expert evidence on those sorts of issues, but if the witness is qualified, then, yes.*”

7.10  **Psychosocial Factors: Medical Specialists’ Perspectives**

Medical specialists' perspectives on occupational therapy opinions on psychosocial factors in work capacity reports generally supported the views expressed by occupational therapists and lawyers, that is, referral to more specialised
psychosocial experts needs to occur in the medico-legal system. However, there were certain circumstances identified in which they welcome occupational therapy comments on psychosocial factors. Owen said most occupational therapists’ FCE reports focus on the claimant’s physical capacities, and psychosocial components are “very, very rare. ... It’s only if [occupational therapists] do a vocational assessment there is certainly significant time, amount of space, given to psychological components, or social components.”

Medical specialists said they prefer standardised measures of psychosocial factors, especially of pain. Transparent and/or validated assessments were important considerations for Matthew and Peter. Matthew said, “And I know what they’ve done and I can then make an assessment of my own on the value of it, of the relevance to what they’ve done. ... I guess my complaint is the lack of transparency.” Peter also emphasised valid results.

Peter: The important feature of the medico-legal reports is that the information requires validation. Validation of the subjective information with objective assessment makes them better. It is difficult to validate some self-report questionnaires. The exception is the SF36 [General Health Questionnaire, Short-form 36]. It is validated to a significant degree.

Interestingly, although medical specialists did not term it “psychosocial,” three of them encouraged occupational therapists to provide more than the claimant’s physical capacities in their reports. They expressed this in terms of “subjective,” “self-report,” “history” “personality” or “softer aspects of disability.” Iamra said, “You’ve got to put the personality of the person into it.” David said he particularly values “the
David: I like there to be consistent history, and when I examine people I spend a lot of time on their history. I think that is important. ‘How did you do it? What did you do? Why can’t you get back to work? What is actually troubling you? What do you perceive to be the problem? Why don’t you think you can work?’ All this sort of thing! … I don’t like to get a detailed history that is totally at variance with that obtained by somebody else. I always look on that with suspicion.

David had “nothing adverse to say” about the quality and usefulness of the “history” taken by occupational therapists. However, he said it is common for psychosocial issues to be referred to a psychologist.

7.11 Summary and Discussion: Opinions on Psychosocial Factors

“Psychosocial” is the term that has been used in the literature to describe those characteristics of individuals’ functioning that are influenced by psychological factors such as their self-perceptions, attitudes, values and emotions, and by social factors such as interactions with people, role performance, social conduct and responses to the environment, and the interplay between those internal psychological and external social factors (Allen & Carlson, 2003). The statements of occupational therapy participants in this research suggested they take different approaches to psychosocial factors in the medico-legal system ranging from focusing on the assessment of several work-related psychosocial factors in some cases, to avoiding assessment in other cases. Several occupational therapists considered it is professionally appropriate for them to report on
claimants’ pain experience, a number of work-related attitudes and self-management skills, mood or emotional status and certain personal and family issues perceived to be impacting on work performance and work participation. The impact of pain on function was identified as the psychosocial factor most commonly incorporated into opinions. Yet, in the medico-legal system, occupational therapists are cautious about how they give opinions on psychosocial factors. Reasons for caution include the need for brief and uncomplicated reports, the difficulties quantifying psychosocial factors and justifying opinions based on these, and that opinions of other experts may be preferred by the courts. One option identified was to incorporate the observed impact of psychosocial factors into assessment of work capacity to complement information on physical functioning, rather than conducting separate standardised assessments of psychosocial factors. The other common approach described was for occupational therapists to refer claimants with psychosocial problems to expert mental health specialists, if this had not already occurred. Occupational therapists emphasised the need to stay within what the courts perceive is their area of expertise.

Lawyers’ responses on this topic indicated some divergence of views on the acceptance of occupational therapy opinions on psychosocial factors. In general, they suggested that the opinions of medical specialists and psychologists are more acceptable to the courts and occupational therapists should confine their opinions to the functional impact of a diagnosis or condition identified by one of these experts. Some responses suggested that personal information about each claimant’s situation may be required rather than formal psychosocial assessment. Similarly, medical specialists believed that psychosocial factors such as pain are generally not the subject of occupational therapy expert opinions. However, they perceived that occupational therapists’ opinions on some subjective factors that derived from interaction with the claimants are needed to complement objective information on physical capacity. These
subjective work-related factors include (a) comments on the claimant’s personality, (b) the claimant’s accounts of the work injury and pain, (c) the claimant’s accounts of the impact of the injury on work capacity, and (d) the claimant’s preferred job options. These factors were amongst the psychosocial factors included in the occupational therapists’ list of psychosocial factors (see section 7.8). Medical specialists said they preferred standardised psychosocial assessments of pain, if these are used. This preferred approach of the medical specialists and lawyers is compatible with aspects of the medico-legal system that separate objective findings on impairment from subjective findings associated with disability (McGill, 2004).

Therefore, there were several reasons for occupational therapists to be cautious about commenting on psychosocial factors in the medico-legal system. This is despite the perceptions of the occupational therapy profession that psychosocial factors are part of its core practice (AOTA, 1994, 1997; Arnold & Devereaux, 1997; V. J. Rice & Luster, 2002; J. Strong, 1996), and the findings that pain-related assessments are incorporated into assessments of people with chronic pain in personal injury cases (Allen et al., 2004; Potts & Baptiste, 1989). Furthermore, psychosocial assessments are commonly used by occupational therapists in conjunction with FCEs in work rehabilitation (Braveman; 1999; Gibson et al., 2005; Jang et al., 1997; Joss, 2002; Keogh & Fisher, 2001; Lo, 2000; Pratt, 1997; V. J. Rice & Luster, 2002). Various occupational therapy authors have identified the need to incorporate psychosocial factors into assessments of work-related function and interventions to improve work performance and work participation of workers with injury (Allen & Carlson, 2003; Gibson et al., 2002; Gibson & Strong, 1998; Moore-Corner et al., 1998; Pratt, 1997; Velozo et al., 1998). However, V. J. Rice and Luster (2002) noted that psychosocial and cognitive aspects of FCEs are generally under-reported in occupational therapy rehabilitation practice and need further exploration, implementation and research.
Overall, the findings on psychosocial factors from the three participant groups supported earlier findings (see section 6.9) that the medico-legal system endorses a hierarchy of expert opinions in areas for which the court requires expertise. This is consistent with some experts being perceived as “more expert” than others on a topic, and that this influences the admissibility and weight of the evidence (D. Tait, 1999, p. 2). The implications of these findings are that the occupational therapists would benefit from further clarification of their role in reporting the impact of psychosocial factors on work capacity so that a more consistent approach can be incorporated into medico-legal practice. In particular, occupational therapists would benefit from the development of work-related medico-legal assessment practices guided by evidence of the impact of psychosocial factors on work performance and work participation. The assessment of these factors needs to closely reflect occupational therapy professional philosophy and conceptual models.

7.12 Other Work-related Assessments

Apart from whole body assessments of physical function, occupational therapists reported routinely assessing cognitive function in sufficient detail to be considered separately. In addition, participants referred to job analysis and pre-work assessments/screening.

7.12.1 Cognitive Assessments: Occupational Therapists’ Perspectives

As presented in section 6.4.1, both specialist and generalist occupational therapists might assess the work capacity of claimants with TBI. Comprehensive assessments for claimants with TBI that were identified by occupational therapists include cognitive assessment, functional physical capacity evaluation, and workplace
assessment. A workplace job analysis aims to identify the cognitive and physical demands of a job a person needs to perform safely.

Occupational therapy cognitive assessments were viewed as often complementing a neuropsychologist’s or psychologist’s assessment of cognitive impairment. Maree said that an advantage of occupational therapists’ cognitive assessments was in identifying established patterns of functioning and opening up opportunities following a neuropsychology report.

Maree: Neuropsych assessments can provide us with clinical data about the client in a specific situation, but they don’t provide information about routine or habituation or life experience. So sometimes we see information in a neuropsych report that can seem quite damning but when we return with someone to a workplace that they are familiar with and structure the strategies that they’re familiar with, it may not be as severe in reality.

Three occupational therapy specialists in TBI, Alex, Maree and Jan, outlined components of their cognitive assessments. These components included impairment measures, simulated and actual work tasks to assess attention, concentration, information processing, distractibility, visual scanning, impulsivity, insight and “all those [other] executive functions as well.” Useful functional implications are derived from the Rivermead Behavioural Memory Test (Wilson et al., 1985), and from the Independent Living Scales (Loeb, 1996), particularly its sub-tests assessing health and safety, problem solving, and money management.

Recommendations for claimants with cognitive impairment form an important part of the expert’s reports, and frequently relate to the solicitor’s question regarding the claimant’s capacity for part-time work, when full-time work is accepted as
unrealistic. Opinions might relate to how realistic any work options are, given the stage of recovery, what further functional improvements can be expected, what work tasks are suitable, and how to vary and grade them. Occupational therapy participants stated that strategies for managing cognitive difficulties might include (a) providing structure in the workplace, (b) reducing physical and cognitive demands causing stress and fatigue, and (c) developing techniques to compensate for memory loss. If the claimant is not able to return to his/her former work, recommendations would include his/her preferred vocational directions and interests and an opinion about how realistic these options are.

7.12.2 Job Analysis: Occupational Therapists’ and Medical Specialists’ Perspectives

A job analysis is a two to three page document detailing the job description, the critical physical demands of the job (James, OT), and the time those demands need to be sustained (Donald, OT). A job analysis routinely complements a FCE and is used to identify the match between findings from each. Of one court case Donald said, “To me that’s a prime example of where, because the OT was involved, I was able to shed some light, through job analysis and functional capacity evaluation, as to the real effect of this accident on this young man’s life.”

Barbara (OT) emphasised the value of obtaining detailed written plans, and photographic or video evidence during a workplace job analysis. She had conducted one job analysis, only to find photos of a more ergonomically-sound workplace were shown to the court. She sought permission to draw this to the judge’s attention, as “these pictures had been taken almost two years after I’d been there, so I didn’t want them to misconstrue my evidence.”
Matthew (M) recounted a case in which the occupational therapist’s “carefully documented” job analysis was important in an anti-discrimination case. The claimant had been unable to perform the inherent requirements of the job so the Tribunal dismissed the discrimination claim. He compared an occupational therapist’s job analysis favourably to an organisational job description.

Matthew: *We were able to demonstrate then that there was a mismatch between the fellow’s abilities or his potential abilities and the actual demands of the job.*

.... *If you rely on a job description, they’re usually a waste of time, they usually tell you who they report to, whether they need a degree and all that other sort of stuff, but they very rarely say ‘Must sit for 6 hours, must ....’*

### 7.12.3 Pre-work Assessments/Screening: Occupational Therapists’ and Legal Practitioners’ Perspectives

Two occupational therapists, James and Ona, mentioned pre-work (i.e., pre-employment or pre-placement) assessment or screening. Employers initiate pre-work assessments to ensure workers can perform the inherent physical requirements of the job and/or to make reasonable workplace modifications to prevent injury or re-injury. James said that the aim of documenting pre-existing injuries is to reduce personal injury claims in a workplace. However, pre-work assessments can result in claims of discrimination. Specifically, a prospective employee might claim the employer has discriminated against them on the basis of an injury or disability and apply to have the case heard in jurisdictions such as the Anti-discrimination Tribunal. James (OT) explained how he adopts a neutral professional problem-solving approach and reminded employers of their legal obligations to avoid discrimination.
James: So the first thing I would do in that situation is rather than say, ‘yes’ or ‘no’, is say, ‘It all comes down to what is required to adjust the position to enable that person to perform the role.’ So I determine that first, and make the employer aware that really the functional evaluation in that case isn’t a means of exclusion for the person: it is more of a means of assisting them in determining what possible adjustments may be required to assist them to employ that person. That’s a decision that they [as employers] ultimately have to make.

Two defendant solicitors referred to pre-work screening. Max noted that occupational therapy workplace assessments of “the general criteria” for a job assist medical specialists to complete pre-employment medical assessments. Jill expressed concern that pre-work screening of people with minor physical injuries and psychological disabilities might result in them being excluded from the workplace, and she said “our society” should be involved with retraining people in this situation.

7.13 Summary and Discussion: Other Assessments

The findings suggested that for people with TBI, occupational therapists can provide an assessment of cognitive function for medico-legal purposes. This finding was consistent with the earlier finding in this research that people with cognitive impairment arising from TBI are the second largest of the groups assessed by occupational therapists (see section 5.20.1). It is also consistent with the literature concerning occupational therapists assessing both function for physical and cognitive demands of the job (Reineke Lyth, 2000) and cognitive and psychosocial aspects of work for people with TBI (Bootes & Chapparo, 2002; Radomski, 2001). Furthermore, occupational therapy opinions on cognitive function in medico-legal proceedings for
people with TBI support the habituation component of the MOHO (Kielhofner, 1995). MOHO emphasises that established habits and routines have a positive influence on the performance of meaningful activities (e.g., work tasks) after injury. However, in the sample of medical specialists and lawyers only one solicitor referred specifically to occupational therapy cognitive assessments, suggesting that occupational therapists may be less well known for this type of assessment among these professionals.

The present findings suggested that, as an injury prevention service, a job analysis may form part of a cost containment process managed by a solicitor in the employer’s interests. A detailed job analysis can be the basis of pre-work assessments that are used to reduce the risk of anti-discrimination claims. The findings also indicated that occupational therapy job analyses may form the basis of a medical specialist’s defence in anti-discrimination proceedings. These findings were consistent with literature supporting the use of a job analysis as the basis of an accurate FCE. V. J. Rice and Luster (2002) stated there was a need for occupational therapists in the rehabilitation context to identify, during a job analysis, the multiple factors on which to conduct the FCE using multiple assessments. These authors described workplace job analysis techniques to increase predictive validity. Similarly, L. L. Perry (1998) supported a valid pre-employment functional assessment that was based on a job analysis, and Fenton et al. (2003) questioned the predictive validity of the use of FCEs solely, in pre-work screening. The present findings can also be related to Huang and Feuerstein’s (1998) finding that musculoskeletal injuries resulted in the largest group of disability-related anti-discrimination cases in the U.S. These authors’ finding need to be considered with the earlier finding (see section 5.2) that the costs of anti-discrimination litigation in Australia may prevent these legal proceedings being undertaken by individuals or unions, and consequently limit the number of requests for job analysis for this purpose.
Although not highlighted in this research, a job analysis is one of the two most frequently provided occupational therapy work rehabilitation services (Deen et al., 2003; Jundt & King, 1998). Perhaps the limited attention to job analyses in this research can be partly explained in terms of the difficulty, for medico-legal purposes, accessing workplaces sites where both job analysis and FCEs can be conducted. In turn, relying on FCEs without accurate job analyses is likely to create other problems relating to the validity of assessments in the medico-legal system. This aspect of occupational therapy contribution in the medico-legal system appears to have previously received minimal attention in the Australian literature and warrants further examination. Thus, the present study extends the current understanding of occupational therapy medico-legal opinions to include those opinions sought by employers and their legal advisors with the specific aim of pre-empting and reducing the employer’s involvement in medico-legal proceedings.

Interpreting Findings, and Forming and Reporting Opinions

7.14 Medico-legal Work Capacity Reports: Occupational Therapists’ Perspectives

In general, occupational therapists mentioned few details about the contents of their medico-legal reports, instead focussing on the processes of medico-legal report writing and interpretation of findings. Barbara was one of two exceptions; the other was Sophie (see Sophie’s FCE in section 7.6). Barbara indicated that the contents of her work capacity reports were presented under the headings of medical status, functional status, and occupational status. Occupational status included education and work history. [Note: The contents of FCE reports were not fully explored in this research as
they were the subject of simultaneous research into the contents of occupational therapy
FCEs for a motor accident insurer (see Allen et al., 2004]).

Most occupational therapists found medico-legal report writing more
challenging than conducting work capacity assessments. Six occupational therapists
commented specifically on this point. Maree said, “I find information gathering quite
easy, quite pleasurable as well. That’s through observation and interview.” Sue agreed
and added, “Assessment is the easiest part especially if you have a pool of assessment
resources.”

Medico-legal reports were described as more time consuming than
rehabilitation reports. John said, “You can’t just churn them out in one day ... [you]
need to ponder over them a lot. ... I try to make sure my arguments are watertight, as
much as possible.” He reflected on his assessment findings for up to 2 weeks.
Madonna’s said that her first report took 30 hours to complete. The usual length of time
reported by occupational therapists for writing medico-legal reports ranged from 1½ to
5 hours. Four occupational therapists identified that the most time-consuming aspects
of report writing include the following: (a) giving more scientific detail; (b) adding
references; (c) ensuring there is support or evidence for every statement; (d) attending
to grammar, writing style and presentation, including formatting; and (e) collating
recommendations and developing an opinion.

The length of occupational therapy reports was found to vary. Lucy rated her
specialised reports of three to four pages as “excellent” and said, “I am very much one
for succinctness and getting straight to the point and being very organised.” Similarly,
Maree described herself as a “tough editor” of information who includes only
justifiable recommendations. In contrast, Antionette, who also rated her reports highly,
said her standard reports are about 30 pages with appendices, including photos. James
said he presents findings in both summary and detailed formats. The front page of his
reports contain the summary and numbered recommendations “because most people don’t read reports anyway. All they want to know is what’s in it exactly – is there a ‘nutshell’ version of it?”

Eight occupational therapists discussed gaining feedback about their reports. From this discussion, the lack of direct feedback about reports appeared to lead to uncertainty about their quality and usefulness. Yet, meaningful feedback may be difficult to obtain. Bill stated that gaining “constructive feedback” is important but has become more difficult to obtain in some legislative environments (e.g., common law CTP) as so many cases go to conference not attended by occupational therapists. Bill said, “I think that is a problem because people may continue to go down the same path not knowing that at the settlement conference what they are saying isn’t in fact being given any weight.” Three occupational therapists who reported asking lawyers directly about their reports said they had received positive feedback.

7.14.1 Interpreting Findings and Forming Opinions: Occupational Therapists’ Perspectives

The professional reasoning needed to interpret findings and form an opinion was discussed in detail by several participants. Five occupational therapists emphasised the importance of forming an opinion, although some acknowledged it is difficult at times. Maree said, “It is our chance to analyse and synthesise [the findings] and give direction about why we have chosen the recommendations we’ve chosen.” Donald considered giving an opinion means making a prediction, and that it is insufficient to say, “‘Fred can’t lift more than 5 kilograms for 20% of the day and his classification’s sedentary.’ ” He considered it is the occupational therapist’s responsibility to say what the findings mean not only in terms of work performance but also the implications for
the person’s chances of getting a job. Madonna and Stan expressed similar views of their roles.

Madonna: *I really just think you have to come up with a reasonable conclusion and that’s what they’re relying on you to do and you’ve got to do it! It is not always that easy, of course, but I don’t have a problem with having to do it. I think I wouldn’t be getting paid this money if I couldn’t do that. If I couldn’t do that, I couldn’t do this work I feel. I’ve got to be able to do it - to make predictions.*

Stan: *You’ve got to reach a conclusion. That’s the objective of the whole report. I don’t think we should just send them 20 pages of graphs and diagrams and stuff, I mean that’s nonsense. I don’t believe they’re asking for that. I think they’re asking for your opinion about it and drawing conclusions and summation.*

James and Antionette urged occupational therapists to confidently use their abilities to form opinions. Both occupational therapists stated that interpretation is more important to lawyers than the assessment tools occupational therapists use.

James: *So what came about with the FCEs was that for many years we tried to make it as scientific as we could, which is good. So we try to use as much evidence as we can get. That’s great, but ... a lot of us forget about professional opinion, about your observation skills. ... So the idea that you have skills and abilities, you use some standardised assessments to assist you but ultimately you’re a professional with training, and with the use of assessment tools you*
make a professional call, a professional judgement. That could be different from
one OT to the next, but ultimately you’re trained to make a judgement.

Antionette: You might get an architect and you might have an average architect
or you might have a very competent architect. Essentially it doesn’t really
matter what pens they use or what tools they use, it’s what’s here in their mind
that will determine what can they come up with. So, essentially you are not
paying for what tools they’re using, you’re paying for what interpretations they
can make.

However, one occupational therapy participant, John, appeared reticent to use
the term “opinion.” He said he understood that only medical specialists and
psychologists could give an opinion in court. Instead, he uses terms like, “I recommend
...” or “I consider something” or “I have strong concerns ...” but avoids saying “ ‘It is
my opinion....’ ”

Several occupational therapists highlighted potential challenges when forming
opinions on work capacity (see Table 31). These potential challenges, and strategies to
address some of them, were each identified by one to three occupational therapists.
Jennifer was one of three participants who reported sometimes being asked by solicitors
to provide a claimant’s “percentage of incapacity,” but she said, “as an OT I don’t see
I’ve got the skills. I will just say that as an occupational therapist my training does not
qualify me to make those sorts of judgements.”
Table 31
Challenges for Occupational Therapists in Forming Opinions on Work Capacity

1. Challenges relating to the medico-legal system
   - Defining the scope of one’s opinion
   - Feeling pressure to interpret findings and draw conclusions favourable to referrer
   - Responding to requests to quantify impairment

2. Challenges relating to assessment
   - Relying solely on findings of a standardised assessment
   - Relying on the claimant’s self-report more than objective assessments
   - Having a lack of research to support an assessment approach
   - Underestimating the limitations of assessment tools

3. Challenges relating to the professional reasoning process
   - Extrapolating from FCE findings to a full-time job (e.g., endurance for a day)
   - Incorporating psychosocial issues into an opinion
   - Identifying a fresh range of job options for each claimant
   - Focussing on what the person can still do
   - Predicting realistic future employability, as it can be like “crystal ball gazing” (Sophie)
   - Having insufficient expertise to interpret findings and make judgements
   - Using the person’s lifting capacity as the sole indicator of his/her work capacity
   - Explaining inconsistencies between self-reported and observed performance
   - Restricting a person’s job options by misunderstanding DOT job demand categories
   - Difficulty supporting intuition that a claimant lacked motivation to return to work
A recurrent challenge raised was forming an opinion about a person’s endurance for work. If a claimant is assessed for 1¾ hours but the request is to assess his/her capacity to work for 10 hours then, John said, the occupational therapist can be faced with a problem of providing an accurate opinion. Stan and Madonna said that they determine endurance based on multiple sources of information over an extended period of time. Madonna requires claimants to complete a log of their activities for the past year and a 3 to 4 hour assessment. She compared her approach positively with those of other experts who make “all-embracing decisions on future work capacity and so forth after a 15 minute session.”

Stan and Barbara found that it was also challenging to support some statements about motivation of claimants. Stan had had difficulty distinguishing between substantiated findings and “less concrete inklings” about a person’s lack of motivation to return to work.

Stan: *I could say that this person is unmotivated, I may even truly believe that, but I then have to think in my mind, ‘That’s a gut feeling about this guy. I don’t put down gut feelings in medico-legal reports. I put down what I see.’*

For Jessie, honesty about the limitations of one’s area of expertise is an ethical issue. An occupational therapist might be able to give an opinion on the functional impact of amputation, but be unable to recommend a prosthesis or advise on its long-term use. Barbara said she was concerned about potential mis-interpretations in reports based only on a [named] standardised assessment with “*very sophisticated looking correlations … that look like they will tell you everything about the person.*” She expected information from other sources when reviewing reports of her occupational therapy colleagues.
Barbara: So I would always make it clear that [the FCE] may well have been validated with a different population, and that if there had been a component of observation, and also maybe a simulated work activity, just a routine type, that that would have added some credibility towards that report.

The final challenge is to avoid recommending the same employment options for claimants. Ona said, “There has been some criticism of occupational therapists sometimes using the same occupations, that is, what the person could potentially do using computer-generated printouts. ... Parking station attendant comes to mind!”

Five occupational therapists identified characteristics of “good” medico-legal opinions (see Table 32). Maree and Lucy related characteristics of good opinions to reasoning processes and reports.

Table 32
Characteristics of Good Medico-legal Occupational Therapy Opinions: Occupational Therapists’ Perspectives

1. Demonstrate an understanding of injury and implications of any residual disability
2. Are logical, transparent and substantiated by the information provided
3. Take into consideration that there might be a contradictory opinion
4. Use unbiased information to form “reasonable and rational conclusions” (Bill)
5. Demonstrate thorough information gathering and careful reporting of the information
6. Emphasise important points and summarises less relevant points.
In Maree’s experience, occupational therapists who give good opinions “are more capable of providing an opinion based on the data they’ve collected rather than their instincts about the data they gather.” Lucy demonstrated how she typically reported her opinions in medico-legal reports, incorporating several principles of good opinions.

Lucy: ‘My opinion is this …. It is consistent with the injury described and reported and the current assessment. There is a significant impairment (or not an impairment) to return to their work as a such and such due to….’ And then I will list … the residual deficit problem and then comment on how that will impact.

### 7.14.2 The Importance of Consistency in Assessment Findings

Consistency is the hallmark of authentic assessment findings. Stan said he looks for logical explanations, “for consistency” and “for what makes sense.” He has found consistency between the self-reported and demonstrated capacities of most people he assesses, thus reducing the problems associated with this aspect of interpretation.

Madonna’s judgement of consistency starts when she greets a person at the door and continues throughout 3 hours of assessment. Madonna said, “So, everything I see and hear at the assessment is measured against each other for consistency but also measured against the person’s history and also measured against what other practitioners have said in their reports.”

Just as occupational therapists routinely look for “consistency” to validate their findings, inconsistencies in findings signalled potential problems for seven occupational therapists. Identifying and accounting for inconsistencies between the observed and reported capacities was widely considered an important aspect of FCE
interpretation. These participants identified that there might be several sources of inconsistency. The sources of inconsistency include: (a) claimants attempting to maximise their symptoms; (b) claimants being selective about the activities they undertake; (c) previous injuries that may complicate, or account for, some inconsistencies; (d) lack of before and after details of the person’s capacity upon which to draw conclusions about loss relating to a particular injury; and (e) psychosocial disability. With regard to the last source of potential inconsistency, Alex said in one case it was “unknown whether that injury was actually causing their lack of work participation or whether it was psychosocial problems that were underlying it, or were they there prior to injury?”

Some occupational therapists described how they dealt with inconsistencies between the claimant’s self-report and their own observations. During assessment, John avoids challenging the claimant about inconsistencies so as to not make the assessment expectations transparent, and for safety reasons while in road traffic. In comparison, Antionette prefers to challenge any inconsistencies as there might be a “good reason” that claimants can do a task sometimes and not others.

Five occupational therapists described how they report inconsistencies in findings. They all stated that they state the inconsistencies in a neutral way without proposing the reasons for discrepancies. Jessie said, “I’ve just got to write what I’ve found, honestly and openly. ... I’ll just say that [the claimant’s self-report] is incongruent with my observations and the level of functional activity that this person was able to undertake. And I’ve had a number of cases like that.” Madonna said she found the best way for her to comment on inconsistencies is to say, “If someone had a problem here I would expect to see this, this and this, and I haven’t.” Further, Madonna demonstrated how she chooses her words.
Madonna: ... *when people have been blatantly dishonest during assessment ... I don’t comment on their honesty or dishonesty. I don’t use words like “malingering” or anything similar. I just make assumptions against observations. Say a person said that he can’t squat, and couldn’t [during formal assessment], but then he did it as you’re leaving. I just tend to say, “He can squat” and try not to make moral judgements. But I guess what I am saying is that’s the most difficult part. It is difficult to truly know that what you’re seeing and what you’re assessing and what you’re saying is real and that you’re not going to be shown a video of them building a house - which has happened. [Laughter].

Despite these examples of how to deal with inconsistencies in findings three occupational therapists agreed that occasionally it is difficult for them to draw conclusions about a person’s work capacity when their findings include a number of observed inconsistencies. Sophie said she does not comment on one inconsistency but looks for “at least three or more inconsistencies, quite significant inconsistencies before I would raise it as a concern.” So, if the grip strength of a person with a back injury is less than normal but everything else appears consistent she does not comment. Madonna and Jennifer said they attempt to draw a conclusion despite major inconsistencies in findings but are conscious that in court they may be asked to justify their opinions. Madonna said, “So very occasionally I’ve said, ‘I can’t comment.’ ”
7.14.3 Recommendations in Opinions: Occupational Therapy

Perspectives

Some occupational therapists stated how important recommendations are in occupational therapists’ medico-legal reports as these add to the sum of damages. Occupational therapists made five distinct categories of work-related recommendations. Each category was identified by five or more occupational therapists and is presented in Table 33. Some occupational therapists addressed issues relating to recommendations in the medico-legal system. (Refer to Chapter 6 for the recommendations regarding jobs that matched the physical, cognitive (and other) capacities of the person).

Table 33
Categories of Occupational Therapy Work-related Recommendations

1. Jobs that matched the physical, cognitive (and other) capacities of the person;
2. Adaptive equipment and modifications to equipment or workplace to assist a person to return to work (e.g., a device to lift 50 to 60 kilograms for a person with a back injury);
3. Occupational therapy interventions or techniques to improve work capacity (e.g., advice about suitable work duties within a job and optimal working postures for comfort, efficiency and safety);
4. Multidisciplinary rehabilitation (e.g., treatment, work hardening, work trial);
5. Recommendations to be undertaken by other organisations or professionals (e.g., training for a different job, referral to medical and psychological services).
Shaunagh and four other occupational therapists proposed some considerations for making recommendations in occupational therapy experts’ reports. These are summarised in Table 34.

Table 34
Considerations for Making Recommendations in Occupational Therapy Experts’ Reports

1. Ensure adequate treating medical and rehabilitation reports come with the referral to avoid repeating the preparation of previous recommendations;
2. Use experience, and think objectively and laterally about possible employment;
3. Avoid unquestioning adoption of claimant’s recommendation (e.g., self-employment);
4. Make independent professional recommendations that are appropriate for the claimant rather than to minimise costs for the defendant;
5. Be aware that minimal intervention enables “people to exercise their own volition and their own independence” (Stan);
6. Look for indicators that costly equipment (e.g., environmental control units, computers, swimming pools) will be used. Indicators include the intended use of equipment, the user’s personality, aptitude for equipment, and adjustment to disability.

Shaunagh considered cost considerations often dominated in medico-legal cases and it is difficult to “work out whether the person is going to use it or [the plaintiff solicitors are] just trying to maximise the claim.” Shaunagh outlined a typical debate
about equipment. She said, “And then that gets into that whole swimming pool debate, you know, whether a swimming pool’s therapeutic or whatever. Well, it’s only therapeutic if the person will get in there and swim.” Maree includes recommendations, if she considers that the claimant needs them, but she recognises that she may not have control over the outcome of her report.

Maree: If I think there is a lot of weight behind a recommendation and I think it would be very beneficial I will prioritise it, but I won’t exclude the recommendation because I don’t think it will be supported by other people. … The fact that my experience tells me [an insurer] won’t provide that doesn’t make my professional judgement any different. My expectations perhaps, but not my judgement! [Laughter].

7.15 Medico-legal Work Capacity Reports: Legal Practitioners’ Perspectives

Four lawyers commented on occupational therapists’ interpretation of findings on which they base their opinions. Of these, three lawyers commented on omissions in interpretation. Martin said, “It’s a pretty critical area where an occupational therapist has to give evidence. We’re talking about predicting the future.” Therefore, he said, the absence of an opinion about future employment and function is a problem. Other omissions included attention to endurance on critical tasks in assessments, overlooking the impact of age on the loss of functional capacity, and sometimes not comparing functional capacity with the pre-injury status. Paogong said, “The OT’s job is to help the judge by setting out all that might support or detract from the provisional opinion that is given.” He qualified the value of occupational therapists’ opinions that he said “sift out and identify the various factors that are relevant,” in the following way.
Paogong: Insofar as they give an expert scrutiny of the relevant areas, they bring out the history and factors. ... But even the ones who are biased will still, at least, bring out in a somewhat expert way a history and detailed account as to the specific matters that are alleged.

Lawyers identified the features of good reports from their individual perspectives. Their individual perspectives are presented in sequence in Table 35.

Table 35
Features of Good Work Capacity Reports: Lawyers’ Perspectives

<table>
<thead>
<tr>
<th>Features of good work capacity reports</th>
<th>Lawyer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give a clear understanding of how injuries limit claimants’ activities</td>
<td>Scully</td>
</tr>
<tr>
<td>Help the insurer clarify any exaggeration of injuries or malingering</td>
<td></td>
</tr>
<tr>
<td>Have more objective “OT observation” than subjective client self-reports</td>
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<tr>
<td>Use a “consistent” professional assessment and recommendation approach</td>
<td></td>
</tr>
<tr>
<td>Have findings and recommendations consistent with injuries and severity</td>
<td></td>
</tr>
<tr>
<td>Have findings and recommendations consistent with other specialists’ reports</td>
<td></td>
</tr>
<tr>
<td>Contain “no outrageous recommendations”</td>
<td></td>
</tr>
<tr>
<td>Contain “no comments outside of their field of expertise”</td>
<td></td>
</tr>
<tr>
<td>Are not “biased” to suit “purely plaintiff or purely defendant” needs</td>
<td></td>
</tr>
<tr>
<td>Are individualised according to claimant, claimant’s situation and injury</td>
<td></td>
</tr>
<tr>
<td>Contain no errors from a template report (e.g., names of other clients)</td>
<td></td>
</tr>
<tr>
<td>Have employment options consistent with injuries and DOT work categories</td>
<td></td>
</tr>
</tbody>
</table>

Table 35 continues.
Table 35 (continued).
Features of good work capacity reports

<table>
<thead>
<tr>
<th>Feature</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay specific attention to potential for employment</td>
<td>Sean</td>
</tr>
<tr>
<td>Have a structured and planned approach to rehabilitation recommendations,</td>
<td></td>
</tr>
<tr>
<td>including goals, strategies, costs and timeframe</td>
<td></td>
</tr>
<tr>
<td>State the physical capabilities</td>
<td>Jill</td>
</tr>
<tr>
<td>Include occupational assessments with employment and training options</td>
<td></td>
</tr>
<tr>
<td>Are original rather than “repetitious” cut-and-pasted template reports</td>
<td></td>
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<tr>
<td>Compare current abilities with pre-injury abilities rather than assume them</td>
<td></td>
</tr>
<tr>
<td>Have a rehabilitation plan</td>
<td>Max</td>
</tr>
<tr>
<td>Are analytical</td>
<td></td>
</tr>
<tr>
<td>Have objective observations rather than relying on claimants’ self-reports</td>
<td></td>
</tr>
<tr>
<td>State the critical and normal tasks of work that have been observed</td>
<td></td>
</tr>
<tr>
<td>Provide information that addresses the employers’ concerns</td>
<td></td>
</tr>
<tr>
<td>Contain accurate information even if it is “not helpful” to the defence case</td>
<td></td>
</tr>
<tr>
<td>Include only necessary and relevant information without repetition</td>
<td>Paogong</td>
</tr>
<tr>
<td>Are not excessively lengthy (i.e., consider costs to legal system)</td>
<td></td>
</tr>
</tbody>
</table>
7.16 Medico-legal Work Capacity Reports: Medical Specialists’ Perspectives

Like the occupational therapists and lawyers, most medical specialists’ references to FCEs were to the corresponding work capacity reports rather than the assessment tools. Medical specialists’ close association with occupational therapy medico-legal reports were suggested by Matthew’s comments that “careful documentation is helpful” to him in court and that one insurer had referred occupational therapy reports for him to review.

Whether FCE reports are valued depends on their quality. Medical specialists consistently identified the features of better and poorer quality reports. These are summarised in Table 36 which includes some medical specialists’ comments to illustrate their views. Matthew stated, “Certainly, the ones I’ve been involved with, they’ve been of variable quality, from some that I thought were very, very good.” Matthew was especially critical of reports that did not have information to show that there was any testing done to substantiate the findings, and emphasised the professional responsibility to give an independent appraisal and not simply accept the claimant’s self-report.

Matthew: I think part of reporting is to make that sort of judgement, assessment. And I guess my real criticism is that there appears to be very little objective measurement assessment and yet that’s really what the skill of an OT is. And then they provide an opinion that is virtually a regurgitation of the self-report.
Table 36

Features of Better and Poorer Quality Occupational Therapy Reports: Medical Specialists’ Perspectives

<table>
<thead>
<tr>
<th>Features of better quality reports:</th>
<th>Features of poorer quality reports:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Succinct and organised, with findings summarised (2)</td>
<td>Too long (e.g., 6-10 pages) (2) or</td>
</tr>
<tr>
<td>Preferably 1-2 pages in length</td>
<td>Sometimes too brief</td>
</tr>
<tr>
<td>Focus on assessing relevant jobs for a person</td>
<td>Difficult to summarise (2)</td>
</tr>
<tr>
<td>Give overall appraisals of suitability of employment</td>
<td>Are not much help, lack specificity</td>
</tr>
<tr>
<td>Based on standardised or non-standardised assessment</td>
<td>The source of information is unclear</td>
</tr>
<tr>
<td>List duration times for assessment components</td>
<td>Lack evidence of objective testing, so reports appear based on self-report</td>
</tr>
<tr>
<td>Compare objective and subjective findings (3)</td>
<td>Lack critical assessment of complaint ( \text{viz à viz} ) initial injury</td>
</tr>
<tr>
<td>Express an independent opinion/appraisal (2)</td>
<td>Lack evidence that self-report of limitations was challenged (2)</td>
</tr>
<tr>
<td>Recommend time-limited work hardening, when appropriately recommended</td>
<td></td>
</tr>
<tr>
<td>Apply profession judgement to the findings</td>
<td>Are not personalised to each claimant</td>
</tr>
<tr>
<td>Demonstrate OT expertise in conclusions</td>
<td>(i.e., sameness of format and content)</td>
</tr>
<tr>
<td>Demonstrate a “fearless opinion” (Edmond)</td>
<td>Too focused on “obsessional detail”</td>
</tr>
<tr>
<td>Provide realistic options for redeployment</td>
<td>Inadequately modified report formats</td>
</tr>
<tr>
<td>State client’s functional limitations</td>
<td>Do not encourage dependence on rehabilitation</td>
</tr>
<tr>
<td>Include appropriate work tolerances</td>
<td>Do not add to a medical examination</td>
</tr>
</tbody>
</table>

*Note.* Bracketed numbers indicate that features were noted by more than one participant.

Matthew read an extract from his evaluative review commissioned by an insurer. He stated what he expected in FCE reports.
Matthew: The sort of thing I might expect to see is, ‘We tested using a certain protocol’ or ‘We used Valpar or we used certain equipment’ and ‘They were able to do this component of Valpar for 8 minutes.’ I’ve got another report ... where all that is reported. ... ‘This is what I was told, this is what I observed myself, and from these things this is what I concluded.’ And in your conclusions, you are entitled, if you wish, to make observations about whether what you were told and what you observed matched up. And yet in these reports, what was observed and what, if anything, was measured are all jumbled in together.

Although Peter acknowledged the value of subjective information from the client, like Matthew and Edmond, he had found that occupational therapists are too eager to accept the honesty of this source and not challenge it with their objective findings.

Peter: Some of the better occupational therapy reports include qualitative information. Better reports often have some reported and some measured limits. However, occupational therapists tend to accept a person’s reported limits, for example, of their lifting ability. That means the process of validation is not good at present in many OT reports.

Peter said occupational therapy “expertise is not used as well as it could be at times,” a comment that supports his belief that occupational therapists can improve the opinions expressed in their reports in number of ways (see also Chapter 8, “Systematically Improving Occupational Therapy Expert Opinions on Work Capacity”). Edmond outlined perceived problems with the formation of opinions. One
was the acceptance of discrepancies between the claimants’ self-reports of sitting limits and the time actually spent sitting in assessment. He contrasted this with occupational therapists’ approach in work rehabilitation.

Edmond: So an OT will say, ‘He says that he can lift 5 kilograms but I have seen him lift 20, and he says that he can walk 500 metres, but I’ve seen him walk 2 kilometres.’ If you go into the workplace and she, usually it’s a “she,” says to the boss, ‘Look, you have to look after this guy and I want you to do this, this and this’ and lean on him quite strongly, and say to the worker, ‘Now I want you to start here but I want you to be here by X’ and they’re quite firm and quite brilliantly effective there. ... But when they come to writing the report they won’t put their chin out and get it knocked down, really, not like we have to. And we are all protected in our opinions by professional protection of our opinions, as I understand, I know the doctors do, maybe the OT’s don’t. I think they do.

Three medical specialists did not appreciate the length or level of detail in occupational therapy medico-legal reports. Edmond, David and Iamra suggested a change of emphasis in line with their interest in occupational therapists’ opinions.

Edmond: You’ll notice the medical reports are usually one or two pages because we know that most people won’t go beyond two. Most of us like a one pager and what we usually do is go to the last paragraph and with the occupational therapy reports you can’t find a last paragraph!
David: *I find the reports very detailed. ... And I am not sort of terribly interested in whether the guy can lift 4½ K.Gs. [kilograms] with his left biceps and 5½ with the right, you know. I am interested in an overall appraisal.*

Iamra also noted his reports were less detailed than occupational therapists’ reports. He did not believe it was the orthopaedic surgeon’s role to set limits on the person’s activities, citing their lack of training in this regard.

Iamra: *[I would write that the person] says, ‘Well, when I lift something heavy off the shelf it hurts my back’. The OT report says so many kilograms and such like. And I again don’t agree with some of my colleagues who write a certificate ‘not to lift 10 kilos’ or something. Generally speaking, we’re not trained to be specific about such things. Orthopaedic training doesn’t equip you for that.*

Owen said that good reports were both specific and pertinent to the client’s situation. He said, *“So, if you were an office worker, you wouldn’t put down lifting capacity ... you’d put down, perhaps, sitting tolerance, or things like this.”* He considered that in formulaic reports of standardised assessments *“a few of the inappropriate things are mentioned.”*

### 7.17 Summary and Discussion: Forming Opinions and Writing Reports

The findings of this study confirmed the literature that, as attendance at court is becoming a rare event, the expert’s reports are now the primary source of expert evidence (Solon, 2001). The three professional groups participating in this study added numerous insights about this primary medico-legal activity. In particular, occupational therapy participants considered writing medico-legal reports more challenging than
doing assessments. The findings have implications for current occupational therapy practice and suggested that medico-legal reports require attention to detail in the more mechanical aspects of writing such as writing style, formatting, and editing. The more difficult part of drawing conclusions and forming opinions requires additional time and expertise compared to reports written for the rehabilitation context. Challenges for occupational therapy experts when developing opinions include a complex range of inter-related factors concerning the medico-legal system, assessment selection and professional reasoning and decision-making (e.g., about the claimant’s endurance for a working day). These challenges have not previously been identified in the literature.

Professional reasoning and decision-making is based on appraising consistency between reported and observed capacities and making recommendations based on them. Accounting for and reporting inconsistencies were challenges identified by occupational therapists. Although this approach to comparing findings for each claimant is consistent with the occupational therapy medico-legal literature (L. Kennedy, 1997a; Shriver, 1989), prior to the present study there was not a detailed understanding of this important professional reasoning and decision-making process. Psychiatrists, Allnutt and Chaplow (2000), agreed that addressing consistencies and contraindications increases the credibility of opinions. Similarly, the Australian Medical Association (1997) advised medical practitioners acting as expert witnesses to explain how they reached their opinions, to justify their assessment methodology and distinguish their opinions from facts. The Australian Medical Association suggested that opinions may also include commentary on other experts’ opinions. In summary, it appears that medical specialists are being encouraged to adopt the format of a research report. The implications for occupational therapists are that this style of writing expert opinions may be expected of other “medical experts,” which in the courts include occupational therapists.
Lawyers and medical specialists in the present study compared better and poorer quality occupational therapy work capacity reports. Legal practitioners considered that good quality occupational therapists reports have an objective statement of physical capacities, a reasonable and detailed rehabilitation plan, and realistic options for employment. Good quality reports are brief and free of typographical errors and bias. Similarly, medical specialists consider that better quality reports rely on objective testing more than self-report, have transparent assessment and reasoning, are shorter, personalised to each claimant, and provide an opinion on the person’s work capacity.

Despite the extensive comments about occupational therapy professional reasoning and insights into professional reasoning when writing medico-legal work capacity reports, one issue noted in the literature was not mentioned in the present study. Specifically, Australian lawyers, Freckelton and Selby (2002), and occupational therapists, Shriver (1989) in the U.S. and Schofield (1999) in the U.K., noted that experts should indicate whether their opinions about outcomes (e.g., work participation) were “possible” or “probable.” Participants did not refer to the extent of certainty of the opinions tended to the court. One possible explanation is that courts prefer experts who can make uncomplicated and accurate predictions and encourage experts to give their opinions in this way. Another explanation is that experts are not using this option fully.

Consistent with findings of Bach and Gudjonsson (1999), that the legal professions criticised long reports from psychologists, and medical specialists, lawyers in this research preferred shorter reports. In contrast to the findings of Bach and Gudjonsson (1999), occupational therapy experts were not criticised by participant lawyers and medical specialists for overly technical language, and so supported earlier findings in the present research that occupational therapists typically convey findings
and opinions in language that is readily understood by key stakeholders (see section 6.2).

In summary, the findings in the current study highlight professional reasoning and decision-making challenges for occupational therapists when forming opinions and writing medico-legal reports. For the first time, two key stakeholder groups, lawyers and medical specialists, have provided criteria to guide the preparation of quality occupational therapy medico-legal reports on work capacity. These findings indicate areas on which medico-legal training and professional development for occupational therapists can focus.

7.18 Conclusion: Occupational Therapy Methods of Assessing, Forming Opinions and Writing Reports on Work Capacity in Personal Injury Cases

This chapter presented the participants’ views on the assessment and report writing methods used by occupational therapists who provide expert opinions on work capacity. In terms of current practice it was evident that occupational therapists choose from a broad range of assessments but prefer non-standardised FCEs to standardised FCEs in the medico-legal system, principally to increase the validity of findings. An eclectic assessment approach combining different types of assessments and sources of information is the most frequently used occupational therapy approach in the medico-legal system. This approach is informed predominantly by qualitative research principles, and supplemented by quantitative research principles. Members of the medical and legal professions made few statements about the assessment process, with which they have little direct experience. However, all participant groups identified that a principal advantage of occupational therapists’ assessments is the professional observation of work-related performance. There was some divergence of opinions among participants about the extent to which occupational therapists should use
standardised assessments and give opinions on psychosocial issues, thus suggesting that the issues require clarification. While the value of occupational therapists assessing the impact of various psychosocial factors on work performance was recognised, there are several barriers to occupational therapists reporting on many psychosocial issues in relation to a person’s condition.

In addition, occupational therapists provided insight into how they form opinions on the work capacity of claimants. Identifying consistencies and accounting for inconsistencies between the various sources and types of assessment information are the foundations of occupational therapists’ opinions. Recommendations to increase work performance and work participation (i.e., the claimants’ employability) are made. Overall, lawyers and medical specialists agreed that the better quality occupational therapy medico-legal reports attend to formatting, are unbiased and provide work capacity opinions on the person’s function and employability.

In the next chapter, Chapter 8, participants’ perceptions about how to improve occupational therapy medico-legal opinions are synthesised. The perceptions relate to relevant trends in the medico-legal system and corresponding recommendations to enhance occupational therapy expertise. Chapter 8 will conclude the results and discussion chapters.
CHAPTER 8
SYSTEMATICALLY IMPROVING OCCUPATIONAL THERAPY
EXPERT OPINIONS ON WORK CAPACITY

8.0 Introduction

The three preceding chapters focused on results and discussion relating to the current contribution of occupational therapy experts to legal decisions about work capacity. The chapters focussed on: (a) understanding the medico-legal system and occupational therapists’ interactions with stakeholders; (b) identifying occupational therapists’ areas of expert opinions on work capacity that assist the courts; and (c) identifying the methods occupational therapists use to assess, form opinions and report on work capacity. This fourth and final results and discussion chapter will focus on the future and participants’ recommendations for improving occupational therapy expert opinions.

The chapter will be presented in two sections. The first section will contain the participants’ perspectives on trends impacting on occupational therapy expert opinions on work capacity. The second section will contain two groups of strategies or principles to develop occupational therapy expert opinions on work capacity. The first group of strategies will include a number of broad professional development strategies for fostering occupational therapy expert opinions on work capacity. The second group of strategies and principles will contain specific recommendations for improving expert opinions through reporting and assessment practices.
8.1 Overview of Trends in the Medico-legal System

Seventeen participants (ten occupational therapists, four lawyers and three medical specialists) identified several trends in the medico-legal system expected to directly impact on occupational therapy expert opinions on work capacity. That is, when invited by the researcher, over half the participants made predictions about the future. However, two medical specialists stated their preferences regarding the future settlement of disputes about work capacity rather than making predictions. Edmond (M) believed that the medico-legal system should reduce the time taken to settle cases. He said that current settlements took 4.7 years on average in Australia and such delays meant that it was difficult to cure a chronic pain condition. He used the metaphor “green poultice” to indicate a popular misconception that settlement would cure pain and suffering. Iamra (M) preferred that, in the future, issues of impairment, rehabilitation, early return to work and redeployment of injured workers were settled by the medical and rehabilitation professions without the involvement of the legal professions, as he believed that this was more appropriate. Iamra stated, “It’s not really a legal problem. You can have the legal system to determine fault, if you want.”

8.2 Trends Influencing Occupational Therapy Work Capacity Opinions

Many anticipated changes were perceived as impacting on the demand for occupational therapy expert opinions on work capacity. Trends were perceived as either increasing demand, decreasing demand or changing the nature of occupational therapy expert opinions.
Occupational therapists and lawyers perceived some trends as increasing the demand for occupational therapy opinions. These trends are presented in Table 37.

Table 37

Trends Increasing Demand for Occupational Therapy Work Capacity Opinions

<table>
<thead>
<tr>
<th>Trends increasing demand</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawyers’ reliance on and respect for OT work capacity opinions</td>
<td>3 1</td>
</tr>
<tr>
<td>Acceptance of occupational therapists’ reports in more jurisdictions</td>
<td>2 1</td>
</tr>
<tr>
<td>Need for specialised work assessments (e.g., cognitive, driving, burns)</td>
<td>1 1</td>
</tr>
<tr>
<td>Increased litigation in Australia due to societal attitude of blaming others</td>
<td>1 1</td>
</tr>
<tr>
<td>Increased litigation due to advertising by solicitors</td>
<td>- 1</td>
</tr>
<tr>
<td>Increased litigation since solicitors introduced ‘no-win, no-fee’ policy</td>
<td>1 -</td>
</tr>
<tr>
<td>Litigation prompted by decreased public funding of disability services</td>
<td>1 -</td>
</tr>
<tr>
<td>Use of OT opinions to reduce potential high costs of liability for defendants</td>
<td>1 -</td>
</tr>
<tr>
<td>Use of OT opinions on work capacity in lieu of orthopaedic surgeons’ opinions</td>
<td>- 1</td>
</tr>
</tbody>
</table>

The acceptance of occupational therapy expert opinions in more jurisdictions was perceived by some occupational therapists and lawyers as reflecting more referrals relating to areas of public liability, medical negligence, industrial relations, unfair dismissal, anti-discrimination, and ill-health retirement claims. In contrast, medical specialists did not suggest any trends that would increase the demand for occupational therapy reports, although members of each participant group perceived some trends as
decreasing the demand for occupational therapy work capacity opinions. These trends are outlined in Table 38.

Table 38
Trends Decreasing Demand for Occupational Therapy Work Capacity Opinions

<table>
<thead>
<tr>
<th>Trends decreasing demand</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Widespread adoption of AMA guides</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Loss of credibility if research is not undertaken to support opinions</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Legislative requirement for pre-trial mediation/conciliation</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Perceived high cost and bias of experts</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Legislation to “cap” compensation settlements</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Two occupational therapists and two medical specialists referred to the increased use of impairment ratings of injuries. Iamra, an orthopaedic surgeon, noted that medical specialists’ opinions had changed with changes to legislation since 1996. Impairment had become the focus of his opinions, rather than “permanent, partial disability.” One occupational therapy participant, Jessie, said that in Victoria, recent legislative changes mean the threshold for an injured worker to access common law has increased from 30% to 40% of whole body impairment using the AMA guides (Cocchiarella & Andersson, 2001). Donald (OT) believed changes to WorkCover Queensland Act (1996, 2003) that increased the decision-making capacity of Medical Tribunals had already led to reduced direct occupational therapy input on work capacity.
in that state. As a consequence of some trends in the medico-legal system impacting on referral rates, the nature of occupational therapy opinions was anticipated to change (see Table 39).

Table 39

Trends Likely to Impact on the Nature of Occupational Therapy Work Capacity Opinions

<table>
<thead>
<tr>
<th>Trends influencing occupational therapy opinions</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OT</td>
</tr>
<tr>
<td>Selection of mutually-agreed or court-appointed experts</td>
<td>2</td>
</tr>
<tr>
<td>Fewer experts called (more reports for mediation, or evidence by phone)</td>
<td>1</td>
</tr>
<tr>
<td>Rigorous questioning that claimants are “commercially unemployable”</td>
<td>1</td>
</tr>
<tr>
<td>Accountability, as more occupational therapists brief defendant lawyers</td>
<td>1</td>
</tr>
<tr>
<td>Threats from other professions beginning to concentrate on function</td>
<td>1</td>
</tr>
<tr>
<td>Experiments with combined medical and occupational therapy reports</td>
<td>-</td>
</tr>
</tbody>
</table>

Members of each participant group identified some proposed changes in the selection of experts. Paogong (L) stated that experts who provide unbiased opinions and who know what the court wants will be used. Among the proposed changes was the use of a single expert who was either court appointed or jointly appointed by the parties. Three participants (two occupational therapists and one medical specialist) had been called as an expert agreed to by both parties and predicted that this trend would continue. Paogong said that the courts of the future may also appoint and select from a panel of two or three experts in an area of expertise, such as occupational therapy.
Paogong suggested that “if the parties can’t agree, then the judge who is going to adjourn the case will appoint the person and the parties then will be able to cross-examine that expert but not call their own evidence.” However, two occupational therapists said one expert might have limited expertise about a range of topics. With respect to the proposal that there might be more combined medical and occupational therapy reports, one occupational therapist, Ona, reported working for an organisation in which three health professionals’ reports could contribute to medico-legal opinions. She had found these combined opinions were difficult to defend in court because of the difficulty of experts reaching a consensus, and of attributing ownership of an opinion to one expert. During participant verification one (unidentified) participant addressed the role of experts being experts for the court.

*This is now law in Queensland (the only state in Australia). Recent legislative changes now require the “expert” to be an “expert for the court,” that is rather than for one side or the other. The expert’s paramount duty is to the court. It doesn’t really change anything but rather just formalises it.*

Overall, Jennifer (OT) predicted “a very big bright future for occupational therapy in both the medico-legal sphere as well as in the work [rehabilitation] area.” She considered that traditional occupational therapy practices of maximising safe function for injured workers had been incorporated into legislation in recent years, and that occupational therapists’ knowledge of psychosocial factors would secure the profession’s future in the medico-legal specialty despite referral to other professions. Similarly, Sean (L) stated that occupational therapists’ practices of analysing jobs and analysing whether the abilities of people with pain would match the job demands was a
reason for the increased demand. He pointed out other reasons for the increased demand for expert opinions including occupational therapy opinions.

Sean: *I think that [occupational therapy] reports will become more and more important as life becomes faster, and people demand things faster, and different disciplines have greater areas of expertise. And I think as society becomes more highly specialised, their role will just be cemented.*

Identifying trends that will come to fruition was a complex task of this research. As a cluster, the key findings about trends had the lowest agreement during participant verification. The agreement about these individual key findings (see Appendix J5) ranged from 14 to 16, of a possible 20.

### 8.3 Summary and Discussion: Trends Impacting on Occupational Therapists

The majority of occupational therapy and legal participants interpreted trends in the medico-legal system as increasing the contribution of occupational therapists to decisions about work capacity in the future. Their most frequently given reasons for a potential growth in demand were perceptions of the legal professions’ increased respect for and reliance on occupational therapy expertise in a wider range of jurisdictions coupled with increased levels of work-related litigation, some of which have been prompted by changes in solicitors’ operating practices. These trends are contextualised within a medico-legal system seeking more specialised expert opinions and faster processing of claims. The reasons for medical specialists not referring to any growth trends are unclear, although the following alternatives are proposed. First, they may not be as familiar with the indicators of growth of occupational therapy services identified by lawyers and occupational therapists. Second, they may consider that the growth of
Occupational therapy medico-legal services was contingent upon improved expertise in tending opinions, about which they spoke extensively (see sections 7.16 and 8.11.3). Third, they may consider that the growth of medical and rehabilitation services outside the medico-legal system is more probable or desirable. The third reason is consistent with the preferences of two medical specialists in section 8.1.

Occupational therapists, lawyers and medical specialists also predicted that some trends would limit demand. Two occupational therapists and two medical specialists made passing reference to the use of AMA guides (Cocchiarella & Andersson, 2001) as reducing demand for occupational therapy opinions. Arup (1998) associated the use of these guides with the increased medicalisation of workers’ compensation settlements and increased standardisation and quantification of impairment. Intensification of this trend would possibly lead to the reduction of occupational therapists’ individualised reports on the impact of injury on aspects of work performance and work participation that were not quantifiable, and predominantly based on a qualitative assessment approach. In Australia, the introduction of the Civil Liabilities Act (CLA) (2003) with an injury scale for quantifying injuries and general damages appears to be part of this trend, although the CLA (2003) does not apply directly to calculations of economic loss and gratuitous care. The trend may also be offset by increased awareness among several participants for the need for assessments of work disability to be individualised and encompass work performance and work participation. The trend to increase the use of impairment measures also needs to be balanced against the body of rehabilitation literature critical of the use of impairment measures as inadequate indicators of participation in the economic or social life of the community (Badley, 1995; Butler & Park, 2000; Cornes, 1997; Cornes & Aitken, 1992; Donelson et al., 1997; Reville et al., 2002). In retirement insurance claims, Sleister (2005) identified that vocational experts offered additional information about claimants.
with injury or illness and their jobs to that offered by claims administrators, and that this information has assisted in the courts’ determination of fair settlements.

Trends to compulsory pre-trial mediation and negotiation and a number of financial disincentives for calling expert witnesses were also perceived as decreasing demand. Overall, participants indicated that, compared to the current situation, the courts of the future are likely to require fewer expert witnesses with greater expertise, that is, they would provide unbiased reports supported by verifiable sources. This is consistent with the trend to greater regulation of experts by the courts. Selby (2004) anticipated that following the introduction of guidelines for expert witnesses in proceedings in the Federal Court of Australia, all courts would develop their own guidelines for expert witnesses. This trend is reflected in Queensland in the introduction of Uniform Civil Procedures Rules, Amendment Rules (No. 1) (2004). Therefore, occupational therapists need to be aware of the literature and specific guidelines relating to the standards for submitting reports and specific rules governing experts and their attendance at court in the particular jurisdictions in which they provide expert opinions (Alcorn, 1997; Federal Court of Australia, 2004; Freckelton & Selby, 2002; Law Reform Commission of New South Wales, 2004; Supreme Court of New South Wales, 2005; Supreme Court of Queensland, 2005).

Two medical specialists indicated that they would prefer to see improved health and rehabilitation outcomes for claimants either through more control of decisions vested in medical and rehabilitation professionals outside the medico-legal system or through faster processing of claims within the system. The latter proposal is partly consistent with recent changes in some jurisdictions. For example, earlier access to funded treatment and rehabilitation and earlier settlement of claims are among the reforms introduced under the Motor Accident Insurance Amendment Act (Queensland) (2000). According to Selby and Freckelton (2002), the trend to improve cost and time
efficiencies in courts such as out-of-court settlements is likely to continue. For example, the introduction of the Civil Liabilities Act (2003) is intended to impact on public liability claims by reducing the eligibility of claimants and the value of settlements.

In some respects the findings of this research are consistent with trends identified in medico-legal literature from the U.K., the U.S. and Australia. In particular, the literature supports the trend towards increased referrals to specialised experts (Cornes & Aitken, 1992; Gore, 1992), and more demonstrable levels of expertise in expert witnesses (Sleister, 2000; Tjiong, 1998). In the U.S., Sleister (2000) indicated that the CV of vocational experts should demonstrate they have completed higher qualifications, conducted research and have peer-reviewed publications, and be able to support their assessment methodology. Sleister linked this trend to the Daubert standard for expert witnesses established in the landmark U.S. Supreme Court case, *Daubert v. Merrell Dow Pharmaceuticals* (1993), in which expert opinions on scientific matters were examined according to scientific principles, rather than whether the opinions were generally accepted in a scientific community. While this case is not directly applicable in Australia, Tjiong (1998) foreshadowed its influence.

Some literature supports those participants in the present study who suggested that jointly-appointed experts and court-appointed experts would be more common. These authors have suggested that the costly and time-consuming adversarial personal injury compensation system in the U.K. may be better served by court-appointed consultants known to be independent, fair and knowledgeable (Woolf, 1996; see also Dimond, 1999; Ward & Braithwaite, 1997). Freckelton (2002) noted that courts in Australia, New Zealand, Canada and the U.S. have rarely used this resource, but that the increasing technical complexity of cases may provide the impetus. Selby and Freckelton (2002) also said that court-appointed experts, otherwise known as
“referees,” may be used to determine an expert issue and report to the trial judge after considering the opinions of experts. Yet, Pesce (2004) stated that members of the medical profession must first agree to their preferred expert witness model before they can advise the courts on a system that should be adopted. Therefore, trends may not represent future outcomes, as a number of factors may exert influences.

Participants did not refer to the wider debate in Australian literature identifying some proposals to reduce adversary in the courts (Mark, 2001; Tjiong, 1998), for further torts-law reforms (Luntz, 2004), or to abolish fault-based systems in favour of more equitable access to rehabilitation and long-term needs (O’Donnell, 2000). In the event of medico-legal decisions being made in a less hostile environment, more occupational therapists who have found the adversarial processes of the medico-legal specialty to be a barrier to their involvement are likely to contribute expert opinions on work capacity. Participants also did not refer to the “disturbing trend where State governments have restricted, through legislation, access to common law for injured workers” (Forrester & Griffiths, 2001, p. 294), or conversely, to a “growing disenchantment by governments with common law as a remedy for personal injury” in work-related cases (Purse, 2000, p. 1).

Overall, predictions of an optimistic future for occupational therapy work capacity opinions need to be considered with the concurrent trends that appear to be reducing demand for occupational therapy opinions, and those which may alter the nature of occupational therapy expert opinions on work capacity. It can be reasoned that while the predicted trends may result in fewer expert witnesses appearing in court, the demand for expert occupational therapy reports required by solicitors or insurers at out-of court settlements, mediation and conciliation will continue.

These findings appear to be the first recorded predictions of the trends impacting on occupational therapy medico-legal opinions. The key implications of
these are that, in future, both treating and independent occupational therapists’ reports should be defensible and legally-useful in a range of jurisdictions. Occupational therapists need to be aware of those trends in legislation, literature and legal precedent to increased reliance on standardised protocols and quantification of findings, although these were only identified by the minority of participants. Occupational therapists need to be prepared to define and justify their conceptual models of practice and assessment methodologies. Furthermore, occupational therapists should consider increasing their credibility through gaining higher qualifications and research experience as suggested by the literature, or through the professional development strategies as recommended by the participants in the following sections of this chapter.

Professional Development Strategies

Participants proposed a number of broad professional development strategies that participants proposed would improve occupational therapists’ expert opinions on work capacity. These strategies for developing expertise are categorised as follows: (a) years and particular types of experience; (b) effective workplace practices; (c) continuing professional and tertiary education; (d) the role of professional organisations; (e) self-development strategies, and (f) professional development resources.

8.4 Years and Types of Experience: Occupational Therapists’ Perspectives

Ten occupational therapists addressed expertise gained by years of experience, and by relevant types of experience. Experience was compared favourably with knowledge-based expertise such as that gained through university education. Sue said lack of experience could not be fully compensated for by knowledge “as experience is
most valuable” and as “there’d only be a limited amount you could pick up by study.” Similarly, Barbara said “the only way [occupational therapists] get experience and become experts is by doing it.”

Some occupational therapists expressed concern about colleagues claiming to be experts without adequate and appropriate experience. Antionette asked, “How can you say you are an expert witness if you haven’t any experience whatsoever?” She was adamant that she would “definitely not!” train new graduates to do medico-legal FCEs. When asked by the researcher whether 2 years’ experience would be sufficient before undertaking a staff training program she replied, “Oh no, I’d go more than that. Probably 3 or 4, or even 5.”

Four occupational therapists considered some years of work experience to be essential, although another two believed it is an individual decision to provide an expert opinion. Barbara did not want to discourage graduates with limited experience from entering the medico-legal specialty. She said, “It all comes back to personality, their ability to market themselves, how they present themselves as being able to provide helpful information.” Stan proposed that after gaining a year’s experience, a graduate could provide an opinion on one or two questions relating to her/his rehabilitation clients with back pain. He offered encouragement for occupational therapists with limited experience who are eager to enter the medico-legal specialty.

Stan: If it’s solid, full-on experience over a few years I don’t see why that wouldn’t make a person as good as someone whose done 20 years and spread it out over that time and been out of date with most of it.

Eight occupational therapists believed the type of experience is important and discussed how work rehabilitation, experience of different workplaces and
understanding the physical demands of particular jobs are desirable for an advanced understanding of the demands of work and a realistic understanding of a person’s employability. Bill said he was “more and more convinced that without that basic [work rehabilitation and work] experience you can assess somebody but you can’t necessarily extrapolate as to how they’d actually perform in the workplace.” Bill was adamant that understanding how people normally work, especially the way people manage to work despite debilitating conditions, is necessary so as to compare them with people assessed for personal injury litigation. Without this understanding, occupational therapists could develop a “skewed understanding” of the extent of difficulties claimants have, and, he said, “You do run the risk of limiting people’s options by suggesting they can’t work or not giving them some hope that there are some things that they can do.”

Barbara said that getting to know “real work” through studying publications and videos of jobs would assist assessors without vocational rehabilitation experience to understand a person’s employability, but she noted that a limited knowledge from one job might give a false impression of other jobs with the same title. Barbara said, “At least realise that warehouses are not the same. You know that an assembly line job that’s packaging in company A is different from packaging in company B.”

8.5 Effective Workplace Practices: Occupational Therapists’ Perspectives

Occupational therapists nominated some effective ways to develop medico-legal expertise at the workplace. Thirteen occupational therapists commended senior workplace colleagues or peers in giving them support or direction. Valued workplace practices included (a) peer review, (b) mentoring, (c) discussion, (d) paid supervision, (e) quality assurance programs, and (f) development of a staff competency system with accompanying criteria. The findings suggested that if workplace practices are to assist
in developing medico-legal experts they need to be provided for extended periods of time. Sophie said that even with “good support and a quality assurance program” it had taken her “probably a good 8 to 12 months” to become confident.

Antionette described her rigorous approach to workplace quality assurance and training in the medico-legal specialty. The steps of her preparation are as follows: (a) learn to conduct a FCE for rehabilitation purposes; (b) study and review the relevant literature including literature on “the different types of assessment;” (c) use case studies by giving the trainee all the findings first and ask her/him to do the recommendations; (d) observe different occupational therapists conducting medico-legal assessments and read their completed reports; (e) observe other occupational therapists doing FCEs, draft their FCE reports for them and have them reviewed by a senior occupational therapist; and (f) conduct a FCE, observed by a senior occupational therapist and then write and discuss the report. Even experienced occupational therapists she employed could expect that if they had a difficult case she would spend 1½ hours reading their report and additional time discussing and questioning them about their opinions. Antionette said, “So it is a fairly aggressive kind of mentoring and it’s not like I say, ‘Just go over there and do it!’ ” ... No medico-legal [report] goes out of this place without me checking it first.”

8.6 Continuing Professional and Tertiary Education: Participants’ Perspectives

Occupational therapists generally supported some form of continuing professional and tertiary education as an effective strategy for enhancing expertise. The majority of occupational therapists perceived that medico-legal education is required in the years following graduation. Details of a post-graduate medico-legal education module for occupational therapists were developed from the recommendations of nine
occupational therapists and one medical specialist. The program is interspersed with teaching and learning strategies proposed by participants (see Table 40). While the strategies in Table 40 are consistent with competencies increasing the credibility of experts in work capacity (see section 6.10.2), they more specifically address details of competencies that can be learnt.

Table 40

Post-graduate Medico-legal Education Module for Occupational Therapists

Components and contents of a medico-legal education module

1. Work, personal injury litigation and occupational therapy
   - The meaning of work in western society
   - Theoretical constructs of work rehabilitation
   - Occupational therapy role in personal injury litigation
   - Industry and Industrial Relations (union and management perspectives)
   - Laws of negligence and legislation governing suing
   - Litigation, legal proceedings, and research on reasons for suing
   - Differences between working for plaintiffs and defendants

2. Pre-assessment preparation
   - Preparing for the assessment
   - Researching background information before the assessment
   - Staying within professional boundaries
   - Costing services, and ensuring payment

(Table continues)
Table 40 (continued).
Components and contents of a medico-legal education module

2. Pre-assessment preparation (continued).
   Understanding and managing expectations of plaintiffs and defendants

3. Assessment and report-writing
   Conducting a FCE [Teaching and Learning Strategy: Workshops]
   Reporting clearly on objective findings and recommendations [Teaching and Learning Strategies: Self-analysis of reports, expert analysis of reports, and analysis of experts’ reports]

4. Attendance at Court
   Being an expert witness
   Anticipating questions and preparing answers in writing
   Understanding the rules of the courtroom
   Preparing for cross-examination techniques

[Teaching and Learning Strategies: Expert witness training using a mock courtroom with full dress, CV and reports; attending other professionals’ court cases; watching presentation techniques on video and hearing hints for experts]

Recommended continuing professional education includes ½ to 2-day seminars or symposia on medico-legal practices conducted by occupational therapists and lawyers, and information sessions provided by rehabilitation advisors employed by insurance companies. A number of tertiary education options are recommended including post-graduate courses in work rehabilitation, medico-legal ethics and expert evidence. One participant referred to a course on ethics and expert witness at the Leo
Cousin’s Institute and the Centre for Continuing Legal Education at Monash University. Barbara (OT) proposed the development of an international post-graduate program for health professionals. Attendance at medico-legal conferences is recommended. The first known international conference on expert evidence was held in Italy in 2002. At this conference a Master Class run by internationally renowned legal experts was offered.

The need for occupational therapists to know and observe the rules of the courtroom was emphasised by Donald (OT) and Jennifer (OT). Donald said, “You can bring yourself unstuck by something as simple as not bowing to the judge as you come into the courtroom, or not swearing on the bible properly.” Jennifer favoured post-graduate students attending a trial and debriefing afterwards. Attending a trial would enable students to observe a courtroom, and compare the reality with impressions created by television programs such as “Rumpole of the Bailey.” However, one occupational therapist and two lawyers said post-graduate education designed for occupational therapists might not be the most influential factor in producing an expert. Stan (OT) said, “Whether a person is going to be any use in this field will depend on lots of things.” He rated motivation and the ability to understand the essential issues in each case as more important than post-graduate education. Scully (L) and Jill (L), however, did not believe occupational therapists needed any special training or education compared to other professions. Instead, Jill praised occupational therapy competencies, but her words implied that developing certain personal dispositions would be advantageous to them.
Jill: *I think the training and the skills that they have are wonderful - and they are probably just too nice and not cynical enough. [Laughter]. ... I think they possibly tend to accept what they’re told [by claimants] too quickly maybe.*

Several suggestions related to the preparation of undergraduate students. Some of these suggestions came from eight occupational therapists who considered their undergraduate preparation for the medico-legal specialty was limited. James (OT) said that undergraduate occupational therapists need to understand that occupational therapy is part of “*a common law based society now and whatever [reports] you write ... they could all go to court and be questioned in some ways.*” Jessie (OT) proposed that “*there should be far more taught in the courses, these days.*” She expanded on this point.

Jessie: *OT reports are very highly valued by the courts now. And, it’s got to the point where they’ll ask for, following a medical, they’ll ask for an OT report first. ... And so there should be far more education about medico-legal aspects of occupational therapy and that’s including doing these reports, report writing in general, and how to avoid litigation.*

Five occupational therapists proposed that undergraduate education should include basic education in work rehabilitation and that these would assist their latter preparation for giving medico-legal opinions on work capacity. This basic education should include: (a) simulated interviews and assessments; (b) formal training in FCE, work hardening techniques, and return-to-work programs; and (c) work capacity assessments at the workplace based on a job analysis. Bill advocated visits to factories and workplaces with heavy work such as engineering. These visits were viewed as essential to understanding working conditions. He proposed that undergraduate students
get assessment experience in psychosocial as well as physical aspects of work capacity. Another proposal was to encourage students to be entrepreneurial in preparation for private practices where most medico-legal services are provided. A final cluster of suggestions related to undergraduate preparation for later giving opinions in the courtroom. Ona favoured experience in public speaking, stating an opinion in public, and debating to develop competence in this area. She said, “In ancient Greek times a lot of learning was done by getting two experts to discuss or debate in front of a class over issues.”

8.7 The Role of Professional Organisations: Participants’ Perspectives

A number of participants addressed the role of professional organisations, principally Occupational Therapy Australia, in developing the medico-legal specialty through promoting ethical professional standards. The recommendations for professional organisations are contained in Table 41.

Table 41

Roles for Professional Organisations in Promoting Ethical Professional Standards

<table>
<thead>
<tr>
<th>Existing or proposed role</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OT</td>
</tr>
<tr>
<td>Offer training and mentoring in the litigation process</td>
<td>2</td>
</tr>
<tr>
<td>Advise on assessments, reporting formats and developing opinions</td>
<td>1</td>
</tr>
<tr>
<td>Develop practice standards to promote ethical opinions</td>
<td>1</td>
</tr>
<tr>
<td>Advise on ethical practices (e.g., marketing and acceptance of gifts)</td>
<td>1</td>
</tr>
<tr>
<td>Give updates on ethical and regulatory issues in professional newsletters</td>
<td>1</td>
</tr>
<tr>
<td>Train and accredit OTs in specialised areas (e.g., TBI, spinal cord injury)</td>
<td>1</td>
</tr>
</tbody>
</table>
Jessie (OT) addressed the need for ethical professional standards when she said that the medico-legal specialty “is quite a seductive area, ... it’s high profile, it’s well paying. I think people have to be really wary of being sucked in, seduced into doing things that ethically and professionally, they really shouldn’t be doing.” Similarly, Paogong (L) recommended that the national association of occupational therapists “state extremely strongly” in its rules or Code of Ethics “the high imperative of unbiased evidence that examines the case fully in respect of all aspects and reports fully without any bias towards one side or the other.” Further, he recommended that impartiality be “rigorously kept up as a culture” that is expected of occupational therapists in the medico-legal specialty, just as, he explained, judges on the bench maintain a strong culture of independence from the government and politics. In addition, Barbara (OT) believed that some ethical professional issues may need to be regulated, noting that regulatory authorities produce legally binding documents, and not a voluntary professional code of practice. One occupational therapist considered that the professional association had played a limited role in the development of the medico-legal specialty, suggesting that private practitioners had taken a greater role.

Another occupational therapist, Rod (OT), proposed that one role for the professional association should be training and accrediting specialised occupational therapists in such areas as spinal cord injuries, orthopaedic injuries, TBI and burns. His rationale was that it is potentially harmful to the occupational therapy profession if members were giving opinions on topics “they don’t really fully understand or lack expertise in.” Sean (L) suggested that the professional association refer to The Royal Australian and New Zealand College of Psychiatrists (1998) to inform ethical standards, and to Allnutt and Chaplow’s (2000) principles of forensic reporting to develop recommendations for “how you put a medico-legal report together, things that should be considered, essential components.”
Although the emphasis in this sub-section was on the role of the professional association in promoting ethical professional standards, elsewhere occupational therapists and lawyers have addressed ethical issues as individual responsibilities. Ethical issues were often associated with the medico-legal specialty and are dispersed throughout the results and discussion chapters. For example, the issue of bias was addressed extensively in Chapters 5 and 6.

8.8 Self-Development Strategies: Occupational Therapists’ Perspectives

Occupational therapists suggested a number of strategies for developing expertise independently. Two occupational therapists identified ten strategies to independently develop as a confident and competent expert witness. These strategies are listed in Table 42.

While some occupational therapists suggested obtaining feedback from solicitors to improve their expert opinions, Maree recognised the disadvantage of this feedback. She said, “So keeping in mind that sometimes the feedback you’re given isn’t given as a constructive feedback. ... it is really about self-appraisal.” Thus, Maree highlighted the strategy of self-appraisal, that is, critically reviewing one’s own reports and performance in court, to independently improve expert opinions. Stan believed that readiness to give an expert opinion was a matter of “self-judgement” and expertise would develop over time and with care.

Stan: A person should always stay within the bounds of what they know. That shouldn’t be a static thing. That’s a very dynamic thing so as people learn more, they increase their boundaries and they increase their ability to deliver opinions.
Table 42

Strategies to Independently Develop as a Confident and Competent Expert Witness

1. Consult with established experts in the field
2. Look at the Court Register in newspapers or Internet to find a suitable trial to attend
3. Visit courts to watch civil trials
4. Attend criminal trials to observe psychiatrists giving evidence
5. Visualise yourself giving a high level performance in the courtroom
6. Visit an empty courtroom to prepare psychologically
7. Spend time preparing oneself and materials for court
8. Develop knowledge through reading medico-legal literature
9. Study the academic literature to find evidence to support your practices
10. Develop public speaking ability as a guest-speaker or lecturer for relevant professions.

8.9 Professional Development Resources: Participants’ Perspectives

Members of each participant group identified professional development resources. Matthew (M) suggested “it might be worthwhile seeing if the Medico-Legal Society could incorporate a category membership, say, for OTs.” The membership of the Medico-Legal Society is currently open to medical specialists and lawyers and co-ordination alternates between the professions (Matthew). Jennifer (OT) said it was useful “to hear what these medicos [in the Medico-Legal Society] were saying. I think that was part of how I got my act together as well ... just really listening.” She also advised members to “take advantage” of the services provided by Occupational Therapy Australia, and listed on their electronic website.
Some participants identified that legal databases such as Austlii and LexisNexis provide other opportunities for professional development. Paogong (L) demonstrated how an electronic legal database enabled access to court decisions such as those of the Queensland Supreme Court by using the keywords “occupational therapist.” He stated that occupational therapists need to support their opinions in a convincing way in order to avoid having judgements based on their reports overturned. He quoted from an Appeal Court judge’s report of a particular case, “In approaching the assessment of future economic loss the learned trial judge began by quoting extensively from the report of the occupational therapist. That is not all that helpful particularly given the video evidence of what the respondent was able to do not long before the trial. Notwithstanding the occupational therapist’s evidence the learned trial judge was not prepared to find that he was unemployable on a commercial basis.”

Other suggested resources are electronic web-sites of motor accident insurers. For example, the Motor Accident Authority – New South Wales has information on Medical and Occupational Therapy panels and Medical Assessment Review. Some articles in legal publications such as “Plaintiff Lawyers” were also recommended.

8.10 Summary and Discussion: Professional Development Strategies

Participants recommended a range of broad professional development strategies to enhance occupational therapy expert opinions on work capacity. Many occupational therapy participants valued expertise based on years of experience. However, the preferred number of years of experience for an occupational therapist before commencing as an expert witness ranged from 1 year’s experience, when giving a limited opinion as the treating professional, to more than 5 year’s experience before undertaking preparation and training to conduct independent personal injury assessments. Although occupational therapists were not consistent about the length of
prior experience of experts, they did indicate consistently that some years are needed and that experience gained in vocational or occupational rehabilitation is essential. This experience generates knowledge of workplaces, work demands in a range of jobs and the way people with and without injury limitations manage to work. These findings can be compared with research on the role of medico-legal occupational therapists in Canada whose minimum experience ranged from 3 to 10 years in addition to business and marketing training (Hall-Lavoie, 1997). Hall-Lavoie found that occupational therapists in Canada “were offering expert witness in the same areas as other professions with master’s or doctoral credentials” (p. 51). It was previously noted in this thesis that there was a difference between the years of experience of the medical specialist and occupational therapy participants (see section 4.4). Based on the work of Benner (1984) in nursing practice, Madill and Hollis (2003) nominated more than 10 year’s experience as the hallmark of an expert healthcare practitioner. Occupational therapists, Craik and McKay (2003), suggested that in excess of 5 year’s experience with the same client group was needed for expert clinical consultants in the U.K. Similarly, the standards of expert physiotherapists in the U.K. Chartered Society of Physiotherapists (1994) (as cited in Dimond, 1999) stipulated a minimum of 5 year’s experience in a specialty along with additional requirements in terms of reputation and qualifications.

The perspectives of occupational therapy participants indicated that the level of expertise for the provision of a medico-legal opinion is not only a matter of the years of experience that she/he has gained, but also depended on the type of experience the occupational therapists has, and the type of opinion the court requests. However, comparison with the literature suggests that while many members of the occupational therapy profession who engage in the medico-legal specialty are adequately prepared and would meet the criteria of experts in terms of years of experience, specialised
experience, reputation and qualifications, some others may be entering it before
developing their professional expertise.

A number of occupational therapists believed that preparation for the medico-
legal specialty should begin in the undergraduate program with education regarding
knowledge of workplaces and workplace assessments, and creating opportunities to
express an opinion or to debate in public. Generally, participants considered that after
graduation is the most suitable time for focused education and they suggested a range
of continuing professional education and post-graduate education opportunities. The
participants’ emphasis on educational strategies is consistent with the advice of Lord
Woolf (1996) who stated that professional people who take on responsibilities as expert
witnesses need to be trained in the legal system, their role in it and how to present
evidence effectively in written and oral forms. Participants in this research extended
this advice by providing a comprehensive range of topics and strategies from which a
post-graduate module of occupational therapy medico-legal education can be
developed. The scope of the module included the role of work and litigation in
industrial societies, and medico-legal proceedings. One strategy was to provide practice
as an expert witness in a mock courtroom with full dress, CVs and FCE reports.

Occupational therapists in this research valued a number of unstructured and
structured workplace practices designed to enhance expertise in FCE and the quality of
report writing. The role of supportive workplace colleagues was highlighted. This
appeared consistent with what Titchen (2001) termed the “critical companionship” of
workplace colleagues who facilitate experiential learning in less experienced
practitioners. A cluster of self-development strategies related to developing competence
and confidence as an expert witness. One recommended strategy emphasised self-
appraisal of reports and performance in court as a means of independently developing
expertise. Prior to this study, Freckelton and Selby (2002) offered general advice for
experts to convey confidence to increase credibility, and that one way to do this was to be familiar with the courtroom. Participants in the present study additionally recommended resources to support the development of expertise including electronic legal databases and web-sites, specialised medico-legal publications, and involvement in a Medico-Legal Society.

Recommendations for professional organisations, especially Occupational Therapy Australia, focussed on their roles in training and establishing standards of best practice (e.g., promoting ethical professional practices, and training and accrediting medico-legal specialists in such areas as spinal cord injury and TBI). In this regard, the blurring of roles of specialists and generalists found in this research has implications for the national professional association’s recent effort to identify and accredit specialists within the profession (e.g., Occupational Therapy Australia, 2002). Specifically, the present study suggests that specialists typically undertake assessments in one or two specialised areas and, in addition, undertake a range of assessments for people with a range of injuries. Similarly, generalists may also undertake some specialist assessments (e.g., cognitive assessments of claimants with TBI) in addition to conducting range of assessments for people with a range of injuries.

**Strategies for Developing Expert Opinions through Assessment and Reporting Practices**

**8.11 Improving Opinions through Assessment and Reporting Practices:**

**Participants’ Perspectives**

In the previous results and discussion chapter occupational therapy participants described how they formed opinions and wrote reports using professional reasoning and judgement, and lawyers and medical specialists identified the qualities of better and
poorer quality occupational therapy expert reports on work capacity (see sections 7.14 – 7.16). In this section, the participants’ recommended strategies and principles for developing occupational therapists’ expert opinions on work capacity are synthesised (see Table 43). Strategies represent purposeful actions intended to improve an outcome, while principles represent rules to guide professional reasoning and decision-making. These professional development strategies and principles complement the broader strategies in sections 8.4 to 8.10.

Table 43
Recommended Strategies and Principles for Developing Occupational Therapy Expert Opinions on Work Capacity

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OT</td>
</tr>
<tr>
<td>1. Strategies and Principles for conducting a medico-legal assessment</td>
<td></td>
</tr>
<tr>
<td>Adopt a consistent professional assessment and reporting template</td>
<td>-</td>
</tr>
<tr>
<td>Know your chosen assessment and be experienced in its use</td>
<td>2</td>
</tr>
<tr>
<td>Confirm findings with alternative assessments (i.e., test the test)</td>
<td>-</td>
</tr>
<tr>
<td>Remember case notes can be subpoenaed with a report</td>
<td>-</td>
</tr>
<tr>
<td>Talk to claimants in a non-judgmental style to elicit their real problems</td>
<td>-</td>
</tr>
<tr>
<td>Adhere to any standardised testing protocol for legitimacy of findings</td>
<td>-</td>
</tr>
<tr>
<td>Challenge the claimants if necessary</td>
<td>-</td>
</tr>
<tr>
<td>Do not foster ideas of illness in claimants when assessing or reporting</td>
<td>-</td>
</tr>
</tbody>
</table>

(Table continues)
2. Strategies and Principles for writing a report

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distinguish between what is reported and observed, and any discrepancies</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Shorten report by reducing detail (e.g., 1½ - 3 pages can be sufficient)</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Write clearly, summarise complicated data and draw conclusions</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Say if non-organic signs are out of proportion to what most people show</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Avoid exaggerating and generalising findings</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Make the important findings meaningful through interpretation</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Provide a thorough account of claimants’ past and present activities</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Include a summary of claimant’s pre-injury abilities for work</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Write in a factual, unemotional way so as not to offend claimants</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>State the claimant’s history of events and reasons for RTW difficulties</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Limit analysis to the assessment that was conducted</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Use “difficulty” cautiously, state degree of difficulty observed (e.g., mild)</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Make reports “as representative of the person as possible” (Peter)</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Check recommendations for consistency with findings in prepared report</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Learn from formats, interpretation and expression in colleagues’ reports</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

3. Strategies and Principles for reporting on employability

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend suitable redeployment (e.g., for degenerative conditions)</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Include recommendations for equipment, modifications, re/training</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Speculate realistically about employment in a particular job or jobs</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Answer the solicitor’s specific questions about employability</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Recommend RTW, rehabilitation for RTW &amp;/or change of employment</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Remember that full recovery is not necessary for employability</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>State work capacity including non-organic factors that influence it</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

(Table continues)
### 3. Strategies and Principles for reporting on employability (continued)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report on the person’s ability to perform the heavier demands of job/s</td>
<td></td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Relate work capacity to injury and recovery</td>
<td></td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Develop a structured and detailed rehabilitation program plan</td>
<td></td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Consider the potential of the employer to pay for recommendations</td>
<td></td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Do not recommend more unsuccessful treatment for pain (e.g., physiotherapy)</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

### 4. Strategies and Principles for preparing an opinion

<table>
<thead>
<tr>
<th>Strategy</th>
<th>OT</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>State an authoritative, confident opinion as an expert in a specialised area</td>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Stay within your area of expertise and, as required, refer to other experts</td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Give an unbiased, thorough and truthful opinion to gain respect at trial</td>
<td></td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Understand plaintiffs’ motives so as not to be lenient on them</td>
<td></td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Understand your attitude to plaintiffs (e.g., identification or sympathy)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Limit your opinion to what was observed during assessment</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Remember the expert’s role is to assist the court</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Consider claimants’ long-term outcomes, not re-referrals or settlement</td>
<td></td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Ensure interpretation results in a reasonable conclusion</td>
<td></td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Utilise available community resources in the recommendations</td>
<td></td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Acknowledge that other information might change your opinion</td>
<td></td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Form and state an opinion about motivation and inappropriate behaviour</td>
<td></td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Be strategic in stating opinions; back up opinions with information</td>
<td></td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Be prepared for the court to decide on your opinion</td>
<td></td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>
8.11.1 Developing Expert Opinions: Occupational Therapy Perspectives

Two occupational therapists offered additional advice to improve opinions. Rod believed that most occupational therapists report inconsistencies in an objective professional manner. He said experts would, for example, say, “‘When the person was distracted I observed that they had full range of movement in their neck or back,’ ” and that reporting of inconsistencies in this way creates confidence in the opinions expressed. However, he stated that a small number of assessors might not report all the inconsistencies they find. He said “withholding information” creates doubts about the assessment findings. In contrast, Stan offered advice about not including information that should not be there. He cautioned his colleagues against exaggerating in reports.

Stan: They can squash you. So we need to be careful of that. ... If you’ve said what you’ve seen, observed, the judge is not going to [criticise] you, I am sure of that. I don’t think you have anything to fear at all but if you’ve become a bit fanciful, or gone outside your area, someone’s likely to find the crack and jump in there!

8.11.2 Developing Expert Opinions: Lawyers’ Perspectives

Some of the lawyers recommended that occupational therapists adopt certain approaches when giving an expert opinion. Two lawyers encouraged occupational therapists to be less reserved when giving an opinion. Paogong said of occupational therapists and other expert witnesses, “They should give their opinion. That’s why they’re called as experts, to give their opinion about things requiring an opinion.” Similarly, Jill encouraged occupational therapists to be less “cautious” when giving an opinion. She said, “I think that as an expert they could offer so much more even if they
were a bit more controversial.” Jill suggested a change of approach and attitude for medico-legal occupational therapists.

Jill: I think their assessments are fine: I’m just not sure that they go far enough. I just think that … when they have got this opportunity in a very specialised field, if they want to get into this medico-legal thing that they could take their reports so much further. And they shouldn’t be so happy to accept history-based assessment.

This advice from Paogong and Jill was qualified by Sean’s advice to occupational therapists. He cautioned that any opinions should be within one’s area of expertise.

Sean: And sometimes, lazy solicitors can ask them questions that are poorly couched, that really do ask [experts] to comment on something outside their expertise. So giving a simple response to a question may not always be a good thing because they might find themselves criticised for expressing opinions about things in which they have no expertise.

Three other lawyers recommended that occupational therapists accept individual responsibility for unbiased reports. Paogong gave the example of how he asked for one respected medical specialist’s reports to be tendered no matter which party requested his opinion. Paogong recalled saying to the court, “‘I don’t want to cross-examine him,’ because I knew that he’d give both sides.” He stated how important it is for occupational therapists to adopt similar practices to this and other medical specialists.
Paogong: Well, they wouldn’t simply accept what was said. They’d make inquiries about history and what he’s doing and they’d even put a few tests to see whether or not the complaints matched the actual disability. ... If you can’t develop a routine of enquiry that will test these things one way or another then you’re not a very good expert at all. I don’t mean for them to be critical to the point of being unfair but merely to try and determine the truth.

Martin said he was unsure of how experts could avoid being partial to the claimant, but he urged occupational therapists to be truthful and unbiased, “to tell it like it is,” and to be aware that there was a “perceived conflict” for medical specialists and occupational therapists receiving large incomes from WorkCover authorities in each state. Similarly, Max said objectivity and impartiality are required in occupational therapy opinions. He emphasised the value that lawyers, such as himself, place on honest, realistic opinions. Max said, “We want the objective assessment and analysis and we want to know those things and if it's not helpful to our case, so be it. ... We'd want to know that, we'd act on that. Yeah, we would. Honestly.” As a defendant solicitor, he warned against a report that “looks like it's trying to work itself to a particular conclusion.” Max compared solicitors’ and occupational therapists’ stances in relation to claimants. In the medico-legal system, he said solicitors can “identify with a client” but in the medico-legal system occupational therapists need to be objective and avoid this tendency.

Three lawyers wanted consistency in some aspects of assessments and reports. Scully and Max said that a consistent occupational therapy report format would make comparison easier for them. Max wanted a structured report format in which objective and subjective findings were reported separately.
Max said that occupational therapists should liaise with the referring solicitor and relevant parties in the workplace rather than becoming legal experts. Occupational therapists should discuss legislation and other legal issues with the referring solicitor and clarify the nature of the referral question. He proposed some questions they could ask.

Max: ‘I've got this letter from you and you're asking me about X, Y and Z. Where are you coming from? What does this have to do with this? Does this have to do with a personal injury claim? Does this have to do with an unfair dismissal? Does this have to do with minimising [risk]?’ … Now, is it really that relevant to this employee going back onto light duties, which is what you seem to be asking for? Shouldn't I be talking about risk assessment and things like that?’

Three lawyers referred to recommendations made by occupational therapists. Sean considered recommendations to be a substantive part of an expert opinion. He stated, “The lack of specific attention [to] the person's potential for employment is problematic.” From Sean’s perspective as a plaintiff lawyer, the structured approach evident in their rehabilitation reports was also needed in the medico-legal system.

Sean: Sometimes the reports, sort of, say, ‘Maybe they should do this and maybe they should do that,’ ‘maybe they should go on a pain program, go to a pain clinic’ or something like that - it's not terribly structured, it's just, sort of, a generalised. … [Say] who’s going to do it, how much is it going to cost, what would you see as the long-term plan … and goal.
With respect to recommendations about employment, Jill advised occupational therapists to provide realistic job options, and retraining and vocational rehabilitation options for people who had difficulty returning to work because of physical disability, especially labourers and older workers. With reference to options for older workers, Jill said, “they don’t seem to explore those.” She said that “commercial unemployability” was too common an expression in occupational therapy opinions, reinforcing “the persona of a victim or an invalid” and “is not necessarily an accurate reflection of somebody’s residual capacity.” Jill realised the employment market might have few options for people with a physical disability and without a “sympathetic employer,” and that the courts need to take this into account. In spite of these considerations she said occupational therapists could be “slightly more objective in the area of the commercial employability. They could probably suggest things, other forms of occupation that a person could do like being a car park attendant or those sorts of things.” They should say what the person can do, despite perceived pressures from plaintiff lawyers to increase the settlement, as this was in the plaintiff’s long-term interests. She explained her situation when in court.

Jill: I mean, if you’ve got a 25 year-old man and you are trying to say, ‘You are never ever going to work again,’ I mean, I think that’s very destructive. Also it is often very difficult to actually go to court and say to a judge, ‘Here is this man who is 25 years old. To everybody else he looks quite normal but he has a 15% disability of his back or a 20% disability of his leg.’ It is very hard to convince a judge that this man has got no commercial employability. He must have something.
8.11.3 Developing Expert Opinions: Medical Specialists’ Perspectives

Similar to the perspectives of two lawyers, four medical specialists advised occupational therapists to be more proactive in stating their opinions confidently in the medico-legal system. In advising occupational therapists to state an opinion, some medical specialists suggested anxiety or fear were barriers for occupational therapists in the medico-legal environment. Edmond compared occupational therapists who “are not willing to put their chin out,” with surgeons who “get used to being hard or tough.”

The following quotes are used to illustrate the congruence and strengths of views expressed by Edmond, Peter and David on this topic.

Edmond: If you wanted to have OT reports being more meaningful and useful, which I think they should be, that’s the way you have to do it. They have to be tough, a little tougher in the writing, not in the application. I think they are brilliant in the application, usually. ... It sounds as though they are running scared and I am not aware of any of them ever being taken to task on it. You don’t want to offend people, you don’t want to upset people, you know people are going to read it. ... You can write things in a way that isn’t offensive.

Peter: More importantly, they need to be aware that in medico-legal work they need to be prepared to put their neck on the line. They need to say it as it is. Don’t be hesitant. If it is apparent then don’t be afraid to give an opinion. ... Occupational therapists need to go out on a limb and apply professional judgement to what they have found.

David: And how many steps they can walk up and can they bend over, etc. It seems to be purely based on that. No general opinion as to whether or not they
perceive ..., you know, they are examining them, talking to them all the time so they could form an opinion. Is this guy motivated? Out of all the people - these are probably busy people - but they must be able to challenge them. ‘I form the opinion that so and so may not be very motivated.’ Maybe they could put that. Might be that they’re scared to put it.

Edmond encouraged occupational therapists to state their opinions by explaining the protection afforded medical practitioners. He believed this protection extended to other expert witnesses.

Edmond: That’s my protection. I know that. If I write on a compo report ‘Fit for work’ - there is no redress. It is my opinion, it is not a statement of eternal fact. It’s my opinion on that day and I am protected by that. I understand that professional opinion is like that.

Matthew recommended not only that occupational therapists give their opinions but that they also be more strategic in giving their opinions by thinking through the various scenarios that could arise in court and backing up their written statements. He said that giving a strategic opinion also means acknowledging that you may not have been privy to all that the claimant is able to do. Matthew advised occupational therapists based on his experiences in court.

Matthew: Very carefully distinguish what you are told, what you observed and then base your opinions on that. Then you’re not going to get ambushed in court if they say, ‘Well, look, doctor, let’s just suppose that that’s not so, that someone was observed riding a bicycle, how does that change your opinion?’
And then you are free to say, ‘I thought this, but that’s more than I expect .... ’

And quite often, in a court, they’re flying a kite and they’re entitled to. And whether or not that opinion flies depends on them, at some earlier or later stage, having produced evidence that the person did ride a bike.

In contrast to these four congruent perspectives were the views of two other medical specialists. Iamra made no specific suggestion stating, “I think [occupational therapists are] experts in what they’re doing,” while Owen stated that he was not qualified to say how occupational therapists could improve what they are doing.

Five medical specialists emphasised the importance of occupational therapists improving the opinions they express with respect to a person’s employability. Peter’s response incorporated a number of issues in relation to opinions on employability.

Peter: [Occupational therapists] are not handling that part so well. It is one of the hardest areas of medico-legal work. From an occupational therapist’s perspective if a patient’s main problem is pain, they know how to assess it but how do they know it is right? Or they can ask, do you think you can work? They can really only speculate about what work people can do. It is much easier if you have a particular job in mind.

Matthew strongly suggested the focus of occupational therapy opinions shift from the categories of DOT (U.S. Department of Labor, Employment and Training Administration, 1991a, 1991b) job demands. A DOT category such as “sedentary” could leave him asking, “What does that really mean?” He said he would prefer occupational therapists to make more specific observations “about jobs that people can
do or might do.” Peter, Edmond and David made additional points about employability opinions.

Peter: *They should report on more of the heavier activities too. This can increase the value of the report. Otherwise you can have the situation where the surveillance video camera may show the person doing what the occupational therapist says they can’t!*

Edmond: *All the stuff is in there - and you are supposed to understand where it is - but they could be a lot better if the occupational therapist in the end is saying, ‘This bloke’s capacity is X and the capacity required for their work is Y. I think there are non-organic factors’ (or whatever you want to say). I recommend a change of occupation, help with return to work in the same occupation, etc., or he can go to work now.’*

David stressed that occupational therapists’ opinions should take into account that people can work despite a slow and incomplete recovery when he said, “*I don’t believe recovery is when the last skerrick of discomfort disappears forever. ... They will wake up and say, ‘My back is still twinging; I am still totally incapacitated.’ Wrong! ... And I think OTs maybe should stress this too.”*

Three medical specialists suggested occupational therapists make recommendations for people who need to change employment. Although Lamra considered occupational therapists gave advice about a range of suitable employment options “*quite well*” he qualified his statement by saying that he thought occupational therapists could be more pragmatic in their recommendations for people with degenerative conditions.
Iamra: *I see a trickle of people who are [supermarket] night fillers; ... the x-rays show they've got a degenerate spine. You see them for the second or third time they've been off with a crook back. ... To go through a program of graduated return to work just defies logic. Yes, you might get them back to work, but they're going to break down again.*

His solution was for occupational therapists to help “*shift them out of there,*” meaning that they recommend suitable redeployment or the claimants will continue to have problems. Like Iamra, David believed occupational therapists need to comment on the suitability of employment of the large number of claimants with back injuries who may be “*mis-employed*” in their occupations, referring to a “*brickie’s labourer*” who had had six back injuries in two years. He explained how opinions could be improved.

David: *I would find it helpful if they said something about, ‘Well, Jo Blogs is suited for this type of work’ or ‘No, I believe he should consider occupational redeployment as I consider he is mis-employed in this type of work.’*

Two medical specialists offered additional advice about wording of statements in medico-legal opinions. Edmond shared two ways that he reported inconsistencies between the organic and non-organic signs in his examination of the claimant. The first way was to comment about Waddell’s signs (Waddell, 1998, 2004). The second way allowed him to report inconsistencies while staying within his area of expertise.

Edmond: *[Waddell’s signs] are so developed now that ... it is acceptable in a medico-legal report to put them in and they are prime indicators of abnormal*
illness behaviour - AIB - and you’ll see that in quite a few reports. … I think OTs could use that. They could say, ‘This person grunts and groans when I examined them, which is not what most people do. When I ask him to do this, he can’t do it and when he doesn’t know I am watching him, he can do it and that’s interesting. That means that it is not purely an organic thing’ and they could work around and do it that way. I think it is quite neat the way the orthopods got around it.

Edmond: The expression I use is, ‘These symptoms are out of proportion to the signs which I have elicited and to those symptoms which I would have expected from such an injury.’ … And if they say, ‘What is it due to?’ Well, I would say, ‘That is outside the area of my expertise and I would suggest a psychologist is the appropriate person to answer that question.’

The corollary of Edmond’s advice is that occupational therapists would benefit from the development of an appropriate checklist of non-organic/psychosocial signs on which to comment in the medico-legal system. This would enable them to comment on inconsistent or abnormal behaviours observed during assessment without needing to explain them fully if such explanation was outside their area of expertise.

Matthew cautioned about using the word “difficulty” in the work capacity reports. He said, “I haven’t seen anybody who doesn’t have difficulty with all sorts of things.” In his assessment reports Matthew stated that he takes care to explain what he means, to back-up his decision, and leave the final decision to the court.

Matthew: And I’m very careful to say, ‘When we walked up and down the stairs, this is what I observed: the individual went one step at a time … he
needed to turn his feet sideways so he didn’t have to flex his ankles as much.’

So, I’d say … ‘I consider that to be a mild difficulty.’ So I’ve expressed an
opinion, but they’ve got the objective assessment. And if they want to apply a
different standard, and, I guess, ultimately, that’s almost what the court does,
they actually determine what a standard is. It’s there and they can make up
their mind. And I’m not backed into a corner there, because there’s the
objective assessment, make of it what you will.

8.11.4 Evidence and Opinions: Participants’ Perspectives

A final cluster of strategies for improving occupational therapists’ opinions on
work capacity related to the use of evidence. Participants from each of the three
professional groups referred to “evidence.” Although participants were generally in
agreement about supporting opinions with evidence, the relationship between concepts
of evidence was not straightforward. Three issues related to evidence were (a) the range
of meanings for evidence, (b) the use of research evidence in reports, and (c) the need
for research evidence to support some occupational therapy assessments and
interventions.

Ona (OT) raised the issue of the different meanings of “evidence” for medical
and legal professions. In particular, she indicated there might be some confusion in the
medico-legal system about the meaning of legal “evidence” and “EBP.” The court uses
expert evidence and wants to know the experience and credibility of experts, the
standard they used for measurement, and the standing of their sources. Ona reported
saying to the court, “Gordon Waddell was obviously the most highly esteemed world
expert on low back pain.” Peter (M) used the term “evidence” in what appeared to be
the legal sense when he advised occupational therapists not only to assess claimants in-
rooms but also to go on-site and “do a job analysis to see if the person can still do the
job." However, on the other hand, Ona pointed out, that evidence in “EBP” can have a different meaning to medical and rehabilitation professionals. According to the NHMRC (1995), the highest level of research evidence is evidence obtained from a systematic review of all relevant research using randomised controlled trials (RCT). In relation to this hierarchy of research evidence and one medical opinion given in court, Ona said “the opinions of respected authorities based on clinical experience, descriptive studies or reports or expert committees were the lowest level of evidence and that’s what was being used ... It was [only] his experience.”

Participants identified that one document based on consensus among experts is widely accepted in the medico-legal system. Iamra (M) referred to the acceptance of AMA guides to permanent impairment (Cocchiarella & Andersson, 2001) as the basis of many medico-legal assessments. However, he stated, “[The A.M.A. guides] are not based on any real scientific research or anything. It’s just a consensus.” These guides were developed by “a group of people getting together and using court judgements,” and refining them over a period of time. Although widely used by medical specialists, he was tentative about such an approach for occupational therapists. He said he did not consider disability indicators could be easily assembled into a table with percentages “because [disability] is difficult to quantify” and the tables would then become “limiting.” Furthermore, Shaunagh (OT) considered that occupational therapists give evidence about areas of functioning in which RCTs do not apply.

Shaunagh: It is the same as any sort of evidence that you’re looking at in your practices and trying to predict things. It’s so incredibly difficult because in the areas we are trying to look at you can’t do random control trials; it is all qualitative information, and that’s the best we can do. So it’s quite hard to be as scientific as perhaps the court system would like.
Some participants addressed the use of research evidence to support statements in reports. Ona (OT) predicted that with the greater emphasis on EBP there would be increasing use of reference lists to support medical and occupational therapy opinions in their reports. Consistent with this expectation, Peter (M) suggested that occupational therapists need to incorporate EBP into their reports. He said, “They need to rely more on Evidence-based Medicine and Pub Med abstracts to inform their recommendations.” Two of the occupational therapists who said they routinely attach or incorporate research evidence into their reports had found it effective. Lucy had used a journal article on the psychological impact of the workplace to explain the failure of a claimant with occupational overuse syndrome to return “to a very unsupportive work environment.” Ona noted that she had supported one work capacity opinion with statistical information about risk of re-injury. Sean (L) explained how an extract from a textbook could be used as evidence in medico-legal practice. He said, “It’s a very persuasive tool,” because “it's very hard for another doctor to say to the contrary to that.” Yet, he suggested that occupational therapists need to use research evidence selectively in their reports. He explained further.

Sean: I've used research in cases of soft tissue injury. ... And occasionally you still come across a doctor who'd say, 'It's all nonsense, whiplash is nonsense.' Well, you'd just produce that research and say, 'That research, you're aware of that, aren't you?' and they say, 'Oh, yes, I think I've seen that.' It's a strong argument to the contrary. ... So yes, it's important and it is useful. Having said that, for a standard functional analysis I don't think you need to footnote every single basis for what you do.
Sean (L) explained how occupational therapists could use research evidence in a briefing with a barrister. In this and the previous example, Sean appeared to equate “evidence” with publication in a textbook.

Sean: *You see in Queensland before you can lead evidence in a court on a particular topic you need to have both sides’ medical reports. So if you speak to your occupational therapist and he says, ‘Well, hang on, what that person’s saying is invalid and I can show you it's invalid,’ and can produce the textbook, then that's useful.*

Some participants noted the absence of particular research evidence that would support occupational therapy opinions. Four occupational therapists referred to the need for research evidence to enhance assessment practices and support recommendations for interventions. For Ona (OT), there was a need for FCEs “*that have been shown to be validated particularly in terms of predictive validity of return-to-work outcomes or particular types of employment.*” Two occupational therapists, and one medical specialist, Peter, identified the need for EBP to support the association between workplace interventions and outcomes. For Maree (OT), the lack of research evidence on functional workplace outcomes for people with TBI hindered the development of occupational therapy expert opinions. Peter (M) considered the lack of evidence-based ergonomics information about the workplace detracted from the contribution of occupational therapists. Contrary to Owen’s (M) belief that occupational therapists used ergonomic principles soundly, Peter said, “*Currently many occupational therapy job analyses are based on 1980s ergonomics theory. Occupational therapists make the assumption that if people break an ergonomic rule that injury will result, and the*
evidence is rarely there.” He pointed out the failure of ergonomics to prevent back pain at work compared to the gains made by no-lift policies in a hospital setting.

8.12 Summary and Discussion: Participants’ Strategies for Developing Expert Opinions through Assessment and Reporting Practices

In this section, the three participant groups added to the findings on assessment and reporting discussed in the previous chapter. In particular, the three participant groups made recommendations for developing occupational therapy expert opinions on work capacity through assessment and reporting practices. They recommended a range of strategies and principles to observe when conducting a medico-legal assessment, when writing a report, when reporting on employability, and when preparing an opinion. The nine most frequently identified strategies and principles in decreasing order of frequency (see Table 42) were as follows: (a) state an opinion authoritatively and confidently as an expert in a specialised area; (b) stay within your area of expertise and, as required, refer to another expert; (c) give an unbiased, thorough and truthful opinion to gain respect at trial; (d) distinguish between what is reported and observed, and any discrepancies; (e) recommend suitable redeployment, especially for people with degenerative conditions; (f) speculate realistically about suitable jobs; (g) include recommendations for rehabilitation, equipment, modifications, training and retraining; (h) adopt a consistent occupational therapy assessment and reporting template; and (i) shorten reports by reducing detail (i.e., 1½ - 3 pages can be sufficient). There were some nuances in the individual advice regarding employability and preparing an opinion resulting in particular recommendations being listed by only one or two participants. This advice included understanding your motives and that of the claimants, and being a strategic thinker to better prepare for cross-examination in court. As Ward and Braithwaite (1997) stated, health professionals are rarely trained to write
medico-legal reports or in medico-legal proceedings. Consequently, these findings about improving opinions through assessment and reporting practices fill a significant gap in the occupational therapy literature by providing specific areas on which occupational therapists’ training and development can focus.

The majority of medical specialists underscored the importance of occupational therapists giving their opinions on work capacity authoritatively and without anxiety or fear. This resonated with the theme from the minority of lawyers who encouraged occupational therapists to extend the opinions that they currently offer and confirmed that the role of experts is to give opinions and expect to be challenged.

Lawyers and medical specialists added further recommendations about medico-legal practices, especially the wording of opinions. Lawyers reiterated the importance of opinions being critically discerning about assessment information, an approach that should lead to honest and unbiased opinions. Saks’ (1990) test of honesty included the extent to which experts include all the information that they did not want the other party to know. This was in contrast to his reminder to readers that “unless an expert witness is also a fact witness, virtually everything else that he or she says on the stand is either “opinion” testimony or the basis of that opinion” Saks’ (1990, p. 300), and as an opinion, by definition, is neither true nor false it cannot be the subject of “lying.” Thus it is difficult for an expert witness to commit perjury.

Some confusion over the term “evidence” was identified, with expert evidence, EBP and research evidence frequently used interchangeably in participants’ statements. One particular issue requiring clarification in the medico-legal system is the relationship between the hierarchy of research evidence and expert witness evidence. In the hierarchies of research evidence (NHMRC, 1995; Sackett, Rosenberg, Gray, Hayes, & Richardson, 1996, Sackett et al., 2000), evidence from randomised control trials is ranked the highest form of evidence and the evidence of experts (i.e., professional
accounts) is ranked the lowest. The implication of these levels of evidence is that the value of expert evidence is diminished in a research context. In contrast, the medico-legal system values the expert’s evidence. Furthermore, Freckelton and Selby (2002) stated that it is not appropriate for experts to “act as conduits for research findings, the views or perceptions of others” (p. 725). Further adding to the confusion, are recent definitions of EBP that incorporate best research evidence with practitioner experience and the patient’s values and preferences (Sackett et al., 2000), as this definition is not reflected in Sackett’s previous and similar research evidence hierarchies. Similarly, Carpenter (2004) said that contemporary experts not only need to be able to interpret research evidence but also need to apply it to individual cases. Therefore, an emerging issue identified in this research is the potential incompatibility between research evidence and legal understanding of evidence from experts.

Similarly, recent occupational therapy literature has found narrow definitions of evidence to be inadequate and have favoured evidence-based approaches more consistent with the systems and complexities of occupational therapy practice (CAOT et al., 1999; Hyde, 2004; M. C. Taylor, 2000). Conceptual models that combine research evidence, client evidence and clinical expertise have been proposed (CAOT et al., 1999; Rappolt, 2003). Indeed, Rappolt (2003) proposed a model of professional expertise in clinical decision-making in which professional expertise is the primary means for integrating and interpreting evidence from the client and research. Tonelli (1999) also defended expert medical opinion vis à vis scientific evidence. Tonelli recast expert opinion based on clinical experience as an alternative and complementary source of evidence to research evidence. In the medico-legal system it is the independent expert’s opinion based on her/his education, training, and experience that are required. This statement further emphasises the importance of independent opinions in the medico-legal system. The implications of these findings on evidence are that
occupational therapists need to clearly understand the similarities and differences between legal evidence and research evidence and consider how they can incorporate the different understandings of evidence into the provision of expert opinions.

Participants from each profession identified the increasing but selective use of research evidence from journals and textbooks to support opinions. The need for research evidence on predictive validity of work-related opinions based on FCEs was identified. Similarly, participants emphasised that research evidence was needed to support occupational therapy interventions for conditions commonly assessed in the medico-legal system such as TBI, and for ergonomic recommendations in reports. Hence, these findings have identified areas of research on evidence-based interventions that are needed to further support occupational therapy medico-legal practice. Such research would potentially address some gaps in evidenced-based ergonomic and work rehabilitation interventions noted by Chan et al. (1999). Although the Waddell and Burton (2000), Cochrane Library (2005) and NHMRC (2004) provided research evidence on aspects of practice relevant to occupational therapists (e.g., the management of acute low back pain), these sites predominantly address acute treatment of impairment and are not specific to occupational therapy interventions and recommendations regarding work performance or work participation. Similarly, OTseeker (2005), the recently developed occupational therapy evidence-based database, currently has limited evidence to support occupational therapy work-related recommendations. Therefore, it is timely that occupational therapists in medico-legal and other work-related practices develop a research agenda that gives priority to those types of evidence that would give the greatest support to their rehabilitation and medico-legal practices.
8.13 Conclusion: Systematically Improving Occupational Therapy Expert Opinions on Work Capacity

This chapter presented participants’ perspectives and experiences relating to the trends in the medico-legal system, their recommendations for broad professional development strategies, and strategies and principles to develop expert opinions through assessment and reporting practices. It is anticipated that these findings will assist occupational therapists in the preparation as expert witnesses on work capacity.

In the next chapter, Chapter 9, “Identification of a Grounded Theory of Occupational Therapy Expertise in Work Capacity,” the grounded theory incorporating four sets of theoretical formulations related to Chapters 5 to 8 will be presented. The grounded theory was verified by the three participant groups.
9.0 Introduction

Part C contained the results of data collection and analysis presented according to four categories of findings. Each category of findings represented coherent patterns within a grounded theory that relates to the concept of occupational therapy expertise in work capacity. To account for the categorisation and interpretation of the data, Part C included numerous direct quotes from participants. Each section of findings was then discussed in relation to the literature. Part C also included some relevant additional comments made by the participants who verified the individual theoretical formulations of the grounded theory in the verification process. The findings from the verification process were closely examined for additional insights to be derived from the participants (i.e., indigenous explanations of the field). The additional comments were selected because they enabled the researcher to confirm, clarify, extend or qualify each theoretical formulation.

Part D will comprise Chapters 9 and 10 and will conclude the research. In the present chapter, Chapter 9, the grounded theory of occupational therapy expertise in work capacity will be presented as four distinct but inter-related sets of theoretical formulations. Chapter 10, the final chapter, will highlight the contributions of the
research to the knowledge-base of the topic and implications for practice, education and future research.

The grounded theory of occupational therapy expertise in work capacity has a number of features consistent with grounded theory methodology. First, the grounded theory of expertise presented in the current chapter relates to the core category of findings of the research that converged around valued, credible and unbiased occupational therapy expertise in work capacity that assists the courts (see sections 3.6 and 6.0). Second, that expertise is required in response to what was identified as the basic social problem, that is, the medico-legal system’s need to deal fairly and economically with claimants (see sections 3.4 and 6.0). Third, through a process of increasing abstraction during open, axial and selective coding phases, the grounded theory aims to provide a conceptual account of the range of participants’ perceptions and experiences (see Chapters 3, 5-8). Fourth, in the grounded theory those events and interactions of particular symbolic importance to the participants were represented. Examples include the interactions between occupational therapists and other key stakeholders when subpoenaed as expert witnesses for the courts (see section 3.2 regarding symbolic interactionism).

The grounded theory is consistent with a theory as being a system of ideas or statements of general principles held as an explanation or account of known or observed phenomena or a group of facts (Oxford English Dictionary, 1989). This grounded theory uses the system of ideas and statements of general principles derived from the participants. The purpose of the grounded theory is to explain and guide occupational therapy practice by outlining the principal roles, interactions and processes undertaken by occupational therapists who provide medico-legal opinions on work capacity. The grounded theory of occupational therapy expertise in work capacity represents current understandings of the expert knowledge, skills and attributes (i.e.,
expertise or higher level competencies) that occupational therapists require in the medico-legal specialty and recommended strategies and principles to enhance them.

The first set of theoretical formulations relate to the medico-legal system in which expert opinions on work capacity are provided and in which occupational therapists interact with other stakeholders with the aim of occupational therapists contributing valued opinions. The second set of theoretical formulations relate to occupational therapists providing valued and credible expert opinions within their areas of expertise. The third set of theoretical formulations relate to occupational therapists assessing, forming and reporting expert opinions in response to requirements of the medico-legal system. The four set of theoretical formulations conceptualises how to prepare for the future as a consequence of participants’ identifying trends in the medico-legal system and the ways to improve occupational therapy expert opinions. The links between these four sets of theoretical formulations and the concept of expertise are illustrated in the Overview: Grounded Theory of Occupational Therapy Expertise in Work Capacity (see Figure 1).
Identifying Occupational Therapy Areas of Expertise that Assist the Courts

Understanding the medico-legal system and interactions with stakeholders

Assessing Work Capacity, Forming Opinions and Writing Reports

Improving Expert Opinion

Figure 1: Overview: Grounded Theory of Occupational Therapy Expertise in Work Capacity
9.1 Occupational Therapy Expertise in Work Capacity: Understanding the Medico-legal System and Interactions with Key Stakeholders

The following set of theoretical formulations represents understandings about the context in which occupational therapists provide their expertise in work capacity. The theoretical formulations relate to aspects of the medico-legal system, and interactions between key stakeholders in the medico-legal system.

There are a number of areas of common and statutory law under which work-related personal injury claims for compensation are considered. Personal injury claims for loss of earning capacity may arise from statutes and jurisdictions associated with workers’ compensation, compulsory third-party motor vehicle insurance, medical negligence, public and product liability, and appeals under administrative law. The medico-legal system applies common law principles to adversarial legal proceedings between opposing plaintiff/claimant and defendant parties. During these proceedings, lawyers for the plaintiff attempt to maximise the compensation for past and future economic losses, that is, damages, while lawyers for the defendant attempt to minimise the losses. Lawyers acting for each party are likely to express the view that their stance is in the long-term interests of plaintiffs. In relation to people of working age, the medico-legal system also includes employment discrimination on the basis of injury/disability, specific rehabilitation to reduce employer liability, and proceedings that conclude at compulsory mediation or conferences. Fewer than 5% of these personal injury cases proceed to trial.

An increasing number of cases in Australian federal and state jurisdictions utilise occupational therapy expert opinions. Occupational therapy work-related opinions may be heard in Supreme and District/County Courts and some tribunals and commissions.
Occupational therapists’ role as experts on work capacity was initially based on their role as treating (i.e., rehabilitation) therapists and on their assessments of function in several areas of daily living. A more specific focus on work capacity has evolved over the last three decades. An increasing number of occupational therapists in Australia and other Western countries provide medico-legal services as consultants in private practice. As independent experts they generally do not simultaneously provide rehabilitation services to the claimants.

It is the occupational therapists’ responsibility, and that of other expert witnesses, to assist the courts to make fair and just decisions. Occupational therapy opinions on claimants’ residual work capacities assist the courts in determining the quantum of past and future economic loss. In the medico-legal system occupational therapy experts are expected to know their areas of expertise and any limitations to them. They must demonstrate their expertise when presenting their opinions in reports and in court.

The expert’s opinions should be unbiased, and contain reasonable recommendations for future interventions. Occupational therapy experts on work capacity need to guard against their opinions being biased as a result of interactions with the various stakeholders, including the referring solicitor, insurer and claimant.

In addition to having relevant knowledge and experience in an area of expertise, there are some desirable characteristics for occupational therapy medico-legal experts. These include: (a) being motivated to undertake the expert witness role; (b) having personal characteristics suited to the medico-legal speciality (i.e., accuracy and attention to detail, integrity, maturity, calmness and confidence when communicating, and strategic, analytical and dispassionate thinking); and (c) being able to identify and use strategies to alleviate stress and anxiety associated with providing expert opinions in the medico-legal system.
In the medico-legal system, solicitors are mainly responsible for communication with all stakeholders including claimants, and for the financial aspects of cases. They initiate the majority of referrals to occupational therapists and provide briefings prior to experts attending court. Occupational therapists’ interactions with solicitors may also include marketing their medico-legal services to them, however a better marketing practice is gaining the courts’ acceptance of their expert opinions. Occupational therapists have developed strategies to ensure payment for their expert medico-legal services within a reasonable timeframe.

Barristers (including QCs and SCs) have two identified roles impacting on occupational therapists. First, they advise on their involvement in medico-legal proceedings, and second, they examine and cross-examine expert witnesses in informal cases (e.g., mediation) and formal cases in court (e.g., trials). Barristers may question occupational therapy expert witnesses on the basis of advice of another occupational therapist, perceived bias, or opinions contrary to the evidence. The metaphors for the adversarial medico-legal system are sporting competitions and battles. These metaphors can be partly attributed to expert witnesses’ perceptions of cross-examining barristers as combative. In contrast, barristers have also assisted in the court valuing occupational therapy opinions, and in the development of the medico-legal specialty within occupational therapy.

Judges weigh competing evidence in cases that go to trial, hypothesise about the future, and provide the rationale for their decisions. Judges are ultimately the stakeholders who must be persuaded by occupational therapy and other professional expert opinions on the impact of an injury. Judges are motivated to arrive at the truth and to do justice. On this basis, occupational therapists may ask for leave to address the judge about matters with a bearing on the case.
Insurers are motivated to counteract demands for apparently high compensation claims by the claimants and their representatives. They may be perceived as ignoring the full impact of injuries on plaintiffs’ lives, such as those reported by occupational therapists and other experts. On the other hand, when experts agree insurers may settle the matter quickly. Insurers can also be advocates for rehabilitation and request occupational therapy services.

Occupational therapists’ expert opinions on functional capacity and employability generally complement the highly regarded and more frequently requested medical specialists’ opinions on diagnosis, level of impairment, prognosis and risk of re-injury.

The largest group of claimants for whom occupational therapists provide opinions are those with musculoskeletal injuries associated with chronic pain. Claimants with cognitive impairment as a result of TBI form the second largest group. Claimants are most frequently referred for an opinion when they are perceived as “stable and stationary.” This stage frequently occurs at 2 or more years post injury.

There is a continuum of claimant responses in the medico-legal system. At one end of the continuum is a group of claimants who are perceived to have had their lives disrupted, are in genuine pain and give an account of their impairment and work capacity consistent with the assessed medical condition. A second group has responses that have become unconsciously distorted in the medico-legal system. Claimants in the second group include some whose responses are ambiguous and who believe that their work capacity is reduced to a greater extent than the level of impairment indicated by objective measures. A third group of claimants is placed at the other end of the continuum. These claimants may malminger, that is, their responses are intentionally exaggerated or otherwise consciously intended to deceive assessors. Consequently, experts need to question the motives and assess the veracity of the claimants’ self-
reports and work performance when forming opinions and providing reports in the medico-legal system. In addition, occupational therapists need to identify any anomalies between different sources of assessment information.

9.2 Occupational Therapy Expertise in Work Capacity: Areas of Occupational Therapy Expertise that Assist the Courts

The following set of theoretical formulations relates to occupational therapists’ areas of expertise in work capacity that assist the courts. Experts on work capacity are able to provide valued, credible, and unbiased expert opinions.

Occupational therapy opinions are of particular value when the legal and medical professions are unable to fully answer questions about work capacity in complex, ambiguous or disputed cases. The distinctive occupational therapy areas of expertise that assist the courts are the assessment of claimants’ functional work capacities, analysis and description of jobs, and relating this information to past, present and potential jobs suitable for claimants.

Specialist occupational therapy expertise in TBI, hand injury, spinal cord injury and driving capacity is being increasingly recognised in the medico-legal system, especially by occupational therapists. However, there is a substantial overlap between specialist and generalist areas of occupational therapy medico-legal expertise. For example, occupational therapists in both groups may assess claimants with chronic low back pain and TBI.

Occupational therapy areas of expertise in work capacity relate to two concepts, function and employability. Function means the ability to perform work (and other daily living) tasks or activities despite impairment, whereas employability means the ability to obtain employment in the open labour market despite impairment. A further distinction is made between present and future employability. When assisting the courts some occupational therapists emphasise their expertise in the claimant’s future.
employability, while other occupational therapists emphasise their expertise in the claimant’s current functional work capacity for past and present jobs for which the claimant is educated, trained or experienced.

Various influences increase the credibility of occupational therapists’ work capacity opinions. These influences include previous relevant work experience, medico-legal experience, relevant competencies, and performance as an expert witness in the courtroom. Credibility in the courtroom includes having a reputation for honesty and responding effectively to techniques used by barristers during cross-examination.

There are inherent pressures to form biased opinions in the medico-legal system. There are a number of strategies for avoiding perceptions of bias including accepting referrals from plaintiff and defendant solicitors, and writing an opinion as if there is an opposing one.

There is a legal tendency to recognise discrete areas of expertise among experts. In contrast, occupational therapists recognise some areas of expertise that overlap with other rehabilitation and vocational experts. In the medico-legal context, occupational therapists may need to clarify that they focus on the impact of an impairment on work performance (i.e., function in work tasks and activities), and workforce participation (i.e., employability) and how their assessments complements the assessments of other experts. In some areas of overlapping expert opinions, the courts may determine that some experts are more expert on a matter than other experts.

9.3 Occupational Therapy Expertise in Methods of Assessing, Forming Opinions and Reporting on Work Capacity in Personal Injury Cases

This set of theoretical formulations relates to expertise of occupational therapists who provide expert opinions on work capacity. It specifically relates to
expertise in methods of assessment, forming an opinion and report writing on work capacity.

In the medico-legal system occupational therapists use a range of work-related assessments that includes FCEs. The range of assessments encompasses standardised assessments, non-standardised assessments, psychosocial assessments, cognitive assessments, job analysis, and pre-work (i.e., pre-employment and pre-placement) assessments. Occupational therapy medico-legal expertise includes understanding the strengths and limitations of available assessments, how they relate to the assessments used by other experts and understanding what the information obtained from each assessment means in relation to medico-legal decisions about economic loss.

An eclectic assessment approach is the most frequently used occupational therapy approach in the medico-legal system. The eclectic assessment approach is informed by both qualitative (non-standardised) and quantitative (standardised) principles. It consists of combining information from various assessment methods and sources in order to compare and validate findings. Information may be obtained from objective measurement such as observation of work-related performance, and subjective measurement such as interview and the self-report of the claimant. Information may be obtained from workplaces, in-rooms and other sites.

A principal advantage of occupational therapists’ assessments is their observation of work-related performance for extended periods. Strategic observation of work-related performance by occupational therapists can be critical in cases of suspected malingering or exaggeration of disability.

Occupational therapists prefer non-standardised FCEs to standardised FCEs in the medico-legal system, principally because of the perceived increased validity of findings. The majority of occupational therapists are reluctant to use standardised FCEs alone, as they lack the required validity and reliability for the medico-legal system. In
particular, they lack predictive validity for workforce participation. Standardised FCEs measure work tasks and activities (i.e., work performance) rather than employability (i.e., work participation) in the workforce for which opinions are required by the medico-legal system. A further related limitation of standardised FCEs conducted in-rooms is that performance may differ from performance in an actual workplace environment, and for this reason, these need to be supplemented with information about workplaces from other sources. However, the reasons for occupational therapists’ selection of other assessment methods are less well understood by lawyers and medical specialists and may require clarification.

Many non-standardised assessments are based on the list of physical demands in the DOT (United States Department of Labor, Employment and Training Administration, 1991a, 1991b). The DOT matrix enables recommendations to be made regarding suitable jobs in one of the five DOT work demand categories from sedentary to very heavy, and for levels of work skills corresponding to the functional physical capacity and qualifications of the claimant. However, occupational therapists using an assessment protocol based on the DOT physical demands may need to consider the validity of their findings for jobs in the Australian context. Furthermore, job match programs that are based on the DOT and designed for the U.S. labour market may not be applicable to Australia. In addition, computer programs based on the DOT provide job matches that are potentially invalid unless the occupational therapist accounts for the person’s residual work capacity. Therefore, occupational therapists who use non-standardised assessments develop their own assessment protocols and adapt them to the individual claimant’s situation and in response to the referral questions.

Portable standardised measures of grip strength, psychosocial factors and spinal function may be used to supplement assessments of physically demanding work tasks. Although these portable measures are not a substitute for observation of claimants
performing physically demanding work tasks, several have acceptable established
levels of validity and reliability based on the self-report and/or performance of the
person with an injury in a rehabilitation context.

There are divergent views concerning the need for occupational therapists to use
standardised FCEs. One view favours the use of standardised FCEs because of their
perceived credibility among some medico-legal stakeholders and the name signified the
assessment protocol undertaken. A second view is that, based on consensus between
occupational therapists in the medico-legal speciality, a consistent occupational therapy
FCE protocol should be adopted. A third view is that further research on FCEs is
needed.

Occupational therapists identified a number of psychosocial factors that impact
on work capacity and that they considered were professionally appropriate for them to
report. These included claimants’ pain experiences, work-related attitudes and self-
management skills, mood or emotional status and certain personal and family issues
impacting on work capacity. The impact of pain on function (i.e., work performance) is
most commonly incorporated into opinions. While occupational therapists typically
incorporate measures of psychosocial functioning into rehabilitation assessments, they
are cautious in giving an opinion on psychosocial functioning in the medico-legal
system. A reason for caution is the difficulty supporting statements and judgements
made during assessment, especially in court. There may not be sufficient scope in the
medico-legal system for a comprehensive assessment and reporting of psychosocial
factors. In addition, other experts are perceived by lawyers and medical specialists as
being more appropriate to comment, especially on causation, motivation and prognosis
of psychosocial conditions. One variation on the previous finding is that several
lawyers and medical specialists prefer occupational therapists to incorporate personal
information about the claimant to complement objective impairment information
provided by medical specialists. As there is some overlap between personal information and psychosocial information some clarification of terms appears to be required.

Occupational therapists identified cognitive functioning for people with TBI as an additional specific area of assessment. This is consistent with TBI being the second largest claimant group.

Despite the advantages of obtaining assessment information from job analyses and FCEs at a workplace, there may be a number of industrial and practical barriers to conducting “in vivo” assessments in the medico-legal system. Alternatives include obtaining photos with a description of the workplace, and a treating rehabilitation occupational therapist’s workplace visit report.

Pre-work assessments are conducted to limit employers’ liability and prevent potentially harmful job placements. Occupational therapists provide job analyses to maximise the validity of these assessments and to assist employers to comply with anti-discrimination legislation.

The major issues for occupational therapists preparing medico-legal reports on work capacity are giving close attention and time to the reports to ensure their integrity and defensibility, and interpreting the information in order to form an opinion.

Occupational therapists analyse and synthesise assessment information to form opinions about claimants’ potential for employment and make recommendations to increase it. Occupational therapists compare information from different sources with their previous experiences of people working with and without injury. Identifying consistencies and accounting for inconsistencies between the various sources and types of assessment information are important foundations of occupational therapists’ opinions. Occupational therapists who extrapolate from the findings to make predictions regarding claimants’ work participation need to state the bases of their opinions, and include any reservations they have about them. One challenge for
occupational therapists is forming opinions about a claimant’s endurance for an extended working day and a week based on an assessment of a few hours. Other challenges include evaluating the claimant’s motivation for work, and identifying a suitable range of job options for each claimant.

There are five categories of occupational therapy recommendations to increase the claimant’s work participation (i.e., employability). The recommendations relate to: (a) suitable jobs that match the claimant’s work capacity; (b) adaptive equipment to assist the claimant to return to work; (c) occupational therapy interventions or modified techniques to improve the claimant’s work capacity; (d) multidisciplinary rehabilitation; and (e) other educational, training or professional services to improve employability. The fifth category includes recommendations for which referrals are not required, such as short trade-related courses, as well as those professionals for whom referrals are required such as medical specialists and psychologists.

Occupational therapy reports are sometimes perceived to lack objectivity and rely on self-reported information. Overall, lawyers and medical specialists agreed about what constituted a high quality occupational therapy medico-legal report. Lawyers require occupational therapists’ opinions to include objective assessment of physical capacities, a reasonable and detailed rehabilitation plan and opinions about employability. They prefer reports that are brief, uncomplicated, free of bias and typographical errors. Similarly, medical specialists consider better quality reports to be those that rely more on objective testing than self-report, have transparent assessment and professional reasoning, are shorter, and personalised for each claimant, and provide an opinion of the person’s work capacity including their employability. However, some legal and occupational therapy experts consider that a report needs to be of sufficient length to support, explain, and qualify an opinion adequately.
Occupational therapists’ reports can provide practical information about the impact of an injury on a person’s work capacity that is free of jargon and based on extended periods of observing the claimant performing work-related activities. Occupational therapists have expert knowledge of functional demands of particular jobs from workplace visits and, therefore, are better able to comment on claimant’s suitability for those jobs, compared to some other experts.

9.4 Systematically Improving Occupational Therapy Expertise in Work Capacity

The following theoretical formulations relate to the trends in the medico-legal system, broad recommendations for professional development strategies, and specific strategies and principles to enhance expert opinions on work capacity through assessment and reporting practices. To develop and maintain expertise, occupational therapists in the medico-legal specialty need to be aware of the trends and undertake some recommended professional development.

The general trend increasing demand for occupational therapy medico-legal opinions on work capacity is the legal professions’ increased respect for and reliance on these occupational therapy opinions to assist with the faster processing of claims in an increasing range of jurisdictions.

However, trends increasing demand may be moderated to some extent by trends to decrease access to common law and cap compensation settlements. These trends may create economic disincentives that decrease demand for occupational therapy work capacity opinions. In the medico-legal system, the medical and legal professions are predicted to continue to have the primary influence on the assessment of workers with injury. Some trends indicate increased medicalisation of the medico-legal system through the widespread use and acceptance of impairment ratings. However, this trend
may be off-set by an awareness of the need for assessments of work capacity to be
individualised and to assess the impact of impairment on work performance and work
participation.

A specific trend emerging as a consequence of the previous trends is that the
courts may seek fewer expert witnesses with greater expertise who are more
accountable and responsive to the needs of the courts. That is, they can provide
unbiased opinions supported with verifiable sources about topics on which the courts
lack expertise. An increased use of court-appointed experts, panels of experts and
mutually-agreed experts is predicted. Recent legislative changes have begun to
formalise that the expert’s primary duty is to be an expert for the court rather than the
referring party.

The increasing trends to compulsory pre-trial mediation and negotiation are
predicted to increase the current trend towards the expert’s report being the primary
source of an expert opinion. In trials, high quality reports often obviate the need to call
the witness for cross-examination.

Although the court decides who it will qualify as an expert, the level of
expertise for the provision of a medico-legal opinion may not only be a matter of the
years of experience that an occupational therapist has gained, but may also depend on
the type of experience the occupational therapist has, and the type of opinion requested
by the court. The minimum number of preferred years of experience for an
occupational therapy expert ranged from 1 year, to answer a question about a client’s
treatment program, to 5 years before commencing training in FCEs for medico-legal
purposes. Experience in occupational and vocational rehabilitation is especially useful
as this generates knowledge of workplaces and jobs, and provides the basis of realistic
recommendations about work participation for people with an injury. In addition,
experience in the areas of chronic pain management and TBI is considered useful.
Professional associations, workplaces, universities and individuals have responsibilities for professional development activities to improve expert opinions. Recommended roles for the professional association are to maintain an ethical culture and ethical practices, train and advise practitioners on using appropriate assessments, reporting formats and developing opinions. A proposed new role for Occupational Therapy Australia is the accreditation of specialists to meet the needs of the medico-legal system. A range of supportive practices, including peer review, mentoring, discussion of complex cases, quality assurance programs and support from colleagues, can be provided at the workplace. Paid supervision and programs to develop staff competencies in medico-legal work capacity assessment and reporting can also be provided at the workplace. Universities are well placed to provide post-graduate education for the medico-legal speciality following some preliminary undergraduate education, while professional organisations may provide continuing education. A comprehensive post-graduate education module for occupational therapists would have components on: (a) work, litigation and occupational therapy; (b) pre-assessment preparation; (c) assessment and report writing; and (d) court proceedings. Individual therapists can independently prepare for the expert witness role and simultaneously develop confidence and competence using strategies such as self-appraisal, independent study and observing other expert witnesses in court. A range of professional associations, electronic databases, websites and publications offer medico-legal resources.

Ten key strategies to enhance occupational therapy expert opinions are: (a) state an opinion authoritatively and confidently as an expert in a specialised area; (b) stay within your areas of expertise and, as required, refer to another expert; (c) give an unbiased, thorough and truthful opinion to gain respect at trial; (d) distinguish between what is reported and what is observed, and discuss any discrepancies; (e) recommend
suitable redeployment, especially for people with degenerative conditions; (f) identify realistic jobs for claimants; (g) include recommendations for rehabilitation, equipment, workplace modifications, training and retraining; (h) adopt a consistent occupational therapy assessment and reporting template; (i) shorten reports by reducing detail, depending on the complexity of the case and evidence needed to support an opinion, and (j) use research evidence selectively to support an opinion.

An emerging issue identified in this research is the potential inconsistency between occupational therapists’ and medical specialists’ understanding of research evidence and the court’s understanding of legal evidence from experts. Occupational therapists would benefit from clarification of the similarities and differences between research and legal evidence. While occupational therapists would benefit from the availability of research evidence to support their opinions, the applicability of some research findings to the presentation of individual clients and their response to interventions cannot be assumed to be accurate.

9.5 Conclusion: The Grounded Theory of Occupational Therapy Expertise in Work Capacity

In Chapter 9 the grounded theory of occupational therapy expertise in work capacity in the medico-legal system was presented. The grounded theory proposes that expertise relates to the following five broad competency areas. An expert: (a) understands the medico-legal context, and the formal and informal interactions with stakeholders; (b) provides valued, credible and unbiased opinions about the claimants’ work capacity, including their work performance and the implications for their workforce participation; (c) selects and justifies suitable assessment methodologies; (d) forms and supports expert opinions expressed in written and oral formats; and (e)
develops and maintains expertise in response to the changes in the medico-legal system.

In the final chapter of this thesis, Chapter 10, “The Conclusions,” the new knowledge encapsulated in this thesis is highlighted and its potential value to practitioners in the field is discussed. Chapter 10 completes the research by contextualising the grounded theory against existing theories on similar topics.
PART D: RESEARCH CONCLUSIONS, CONTRIBUTIONS AND IMPLICATIONS

CHAPTER 10

THE RESEARCH CONTRIBUTIONS AND IMPLICATIONS

10.0 Introduction

This chapter will conclude the research by identifying the extent to which the aims and objectives have been met with reference to the outcome, a grounded theory of occupational therapy expertise in work capacity. The significance of the research will be related to the development of the occupational therapy profession. After consideration of the limitations of the research, the implications of the major findings for occupational therapy practice will be discussed along with recommendations for further research.

10.1 Addressing the Research Aims and Questions

The quest to understand the contribution of occupational therapists to decisions about work capacity in the medico-legal system was the impetus for this research. The research was able to address the following research aims and provide substantive answers to the following series of related research questions.

Research Aims:

1. To understand the contribution of the occupational therapy profession to medico-legal decisions about work capacity;

2. To identify current occupational therapy medico-legal work capacity evaluation and expert witness practices; and
3. To identify strategies to improve occupational therapy expert opinions on work capacity.

The research addressed the following questions:

(a) What are the experiences and perspectives of occupational therapists providing expert opinions on work capacity?

(b) What are the experiences and perspectives of members of legal and medical professions who request and/or peruse occupational therapists reports about their clients’ or patients’ work capacity?

(c) What are the assessments of physical, cognitive and psychosocial function that occupational therapists report to the courts and what is the basis for their inclusion in the assessment of work capacity?

(d) How is quantitative and qualitative information in occupational therapy reports interpreted by the courts?

(e) What information and education do occupational therapists need to improve their expert opinions on work capacity?

(f) What grounded theory of occupational therapy contribution to medico-legal decisions about work capacity is embedded in the data?

The three research aims and research questions (a) and (b) were specifically addressed in the results and discussion of Chapters 5, 6, 7 and 8, and the corresponding sets of theoretical formulations in the grounded theory of occupational therapy expertise in work capacity that were presented in Chapter 9. The contribution of
occupational therapists was contextualised in Chapter 5, “Understanding the Medico-legal System and Interactions with Stakeholders.” In Chapter 6, the distinctive contribution of occupational therapists was addressed and the value of their contribution was clarified. In particular, the following theoretical formulation is directly relevant to the first research question. It received full agreement from the 20 participants who responded during participant verification.

*Occupational therapy opinions are of particular value when the legal and medical professions are unable to fully answer questions about work capacity in complex, ambiguous or disputed cases. The distinctive occupational therapy areas of expertise that assist the courts are the assessment of claimants’ functional work capacities, analysis and description of jobs, and relating this information to past, present and potential jobs suitable for claimants* (p. 367).

This finding confirms that during the last three decades occupational therapists have extended their role in the medico-legal system from one with a generic focus on ADL to one in which they also provide authoritative and comprehensive opinions on work capacity. In addition, the current research is the first known study to identify ways in which the work rehabilitation and medico-legal systems may overlap. The research has highlighted that a range of work rehabilitation services undertaken by occupational therapists can potentially be “medico-legal.” This situation appears to have arisen in Australia since the 1990s with the trend to insurer management of personal injuries (e.g., motor accident, workers compensation, and public liability). Under legislation, national and state-based regulatory authorities and insurers may have dual responsibility for rehabilitation and the costs of personal injuries on behalf of employers, government and other parties who could be liable for compensation and rehabilitation in statutory or
common law (e.g., Comcare, 2005; Motor Accident Insurance Commission, 2005; Q-Comp, 2005). An emphasis on early work rehabilitation and injury prevention aims to reduce the exposure of insured parties to liability for personal injuries. Having an occupational therapist undertake a job analysis and make recommendations to facilitate an early return to work is an example of these work rehabilitation services.

The second research aim was addressed throughout Chapter 7, “Assessing Work Capacity, and Forming and Reporting Opinions on Work Capacity,” and was summarised in the corresponding set of theoretical formulations in Chapter 9. In addition, Chapter 7 specifically answered research questions (c) and (d) about assessment components and responses of stakeholders to different types of assessment information in the medico-legal context. These findings provided fundamental insights into current occupational therapy medico-legal assessment practices, and the perspectives of medical specialists and lawyers about these practices. Specifically, the findings provide guidance to occupational therapists on how to conduct assessments and write high quality reports, and also clarify why certain assessment components and approaches may be considered problematic to some stakeholders in the medico-legal context. Further, strategies to overcome persistent problems in medico-legal report writing were identified. The implications of these findings for professional practice are that occupational therapy experts need to understand how their opinions can answer medico-legal questions, and how to make their opinions more legally useful by addressing these questions in their assessments and expert opinions. Occupational therapists also need to conceptualise their contribution in terms of the client’s workforce participation (i.e., employability) and not only in terms impairment and work performance (i.e., work tasks and activities). The emphasis on work performance and work participation is consistent with the conceptual framework proposed by Sandqvist and Henriksson (2004), and which is based on a number of relevant conceptual
frameworks used by occupational therapists. These findings have addressed a gap in the literature and are expected to significantly assist in the future development of the occupational therapy medico-legal specialty.

The third research aim was directly addressed in Chapter 8, “Systematically Improving Occupational Therapy Expert Opinions on Work Capacity.” In Chapter 8, research question (e) was also answered by identifying trends in the medico-legal context that are likely to impact on occupational therapy expert opinions. Over time, occupational therapists need to continue to adopt strategies to align their practices with changes in the medico-legal system. Because social processes tend to change over time, actions and interactions need to change to stay aligned (Strauss & Corbin, 1998).

The remaining questions, (a), (b) and (f), were addressed throughout all the chapters, each of which referred to the collection and analysis of the experiences and perceptions of the three participant groups (Chapters 5-8), and the grounded theory embedded in the data (Chapter 9). The grounded theory highlights that occupational therapy medico-legal expertise in work capacity means having an advanced understanding of the medico-legal system and meaningful interactions with other stakeholders, providing opinions within one’s areas of expertise in written and oral formats, adopting a defensible assessment methodology that facilitates the formation of credible expert opinions, and continuing to enhance expertise through the ongoing use of professional development strategies. Thus, the research aims and research questions have been systematically addressed by the research.

10.2 The Significance of the Research Contributions

Prior to the present research, the literature indicated that occupational therapists in the medico-legal speciality lacked a comprehensive understanding of their contribution to medico-legal decisions about work capacity of clients with personal
injury claims. The existing literature on the medico-legal speciality mainly consisted of intermittently published professional accounts based on personal experience, not research data. These accounts provided information on professional reasoning and decision-making about the selection of work-related assessments and formation of opinions about work capacity. Furthermore, the literature lacked information on the perspectives of different stakeholders and how the professional contribution of occupational therapists could be enhanced. In summary, there was limited medico-legal literature that was up-to-date, research-based, occupational therapy-specific, work-related and informed by relevant stakeholders.

The present research extends the research of Hall Lavoie (1997) into the role of occupational therapy expert witnesses in Alberta, Canada, and the medico-legal practice guidelines of Occupational Therapy Australia - New South Wales (1998). The study also reinforces the findings of Innes and Straker (2002b, 2003) that occupational therapists and physiotherapists in Australia working in both rehabilitation and medico-legal contexts use qualitative and quantitative approaches in work-related assessments. However, the present research extends the previous studies and guidelines by collecting and analysing the detailed views of three participant groups with experience of occupational therapy expert opinions on work capacity. These views contribute to an understanding of the medico-legal specialty by contextualising expert opinions on work capacity within the medico-legal system, identifying occupational therapists’ areas of work capacity expertise that assist the courts, specifying the assessment and reporting methods that medico-legal occupational therapists use to form opinions on work capacity, and synthesising strategies to enhance expertise in this specialised field. It is anticipated that these findings will enhance occupational therapists’ preparation for a future in the medico-legal specialty.
The research has highlighted that the medico-legal work-related services offered by occupational therapy experts are consultancies, and that these services need to differ from the collaborative approach used with clients in the rehabilitation context. While the literature has repeatedly emphasised that occupational therapists engage in client-centred and collaborative rehabilitation practices (Law, 1998; Law & Baum, 2001), these practices may not be appropriate in consultancies where the occupational therapist’s primary responsibility is to the court and the court’s representatives.

Consistent with the methodology adopted, the grounded theory of occupational therapy expertise in work capacity was compared with the literature once it was identified (Kendall, 1999). The findings of this current research resonated with the literature on expertise relevant to the health professions (Benner, 1984; Craik & McKay, 2003; Dreyfus, 1982; Dreyfus & Dreyfus, 1986; Gwyer, Jensen, Hack, & Shephard, 2004; Jensen, Gwyer, Shepherd, Hack, 2000; Higgs & Jones, 2000; Higgs & Bithell, 2001; Madill & Hollis, 2003; Resnik & Jensen, 2003; Tonelli, 1999).

Dreyfus (1982) and Dreyfus & Dreyfus (1986) presented a five-stage model of human skill acquisition that demonstrated a continuum from novice to expert. The model, developed with reference to expertise in such activities as playing chess and driving cars, was applied to business executives. Dreyfus and Dreyfus identified that an expert has four characteristics, each relating to experience. Experts can (a) recognise components of a situation as being similar to those previously experienced, (b) understand the salience of the components, (c) view the situation holistically, and (d) derive predictions and decisions intuitively rather than consciously. These characteristics are generally consistent with the findings of the present research that emphasised expertise based on experience.

Building on the foundational work of Dreyfus and Dreyfus, Benner (1984) examined expertise in nursing practice and developed criteria for locating clinicians on
the Dreyfus and Dreyfus (1982, 1986) continuum. Benner proposed that expert nurses were characterised by more than 10 years of experience, and an intuitive and efficient clinical reasoning style. Benner, Tanner, and Chesla (1996) extended Benner’s (1984) work to describe the role of patients in contributing to nurses’ deliberate clinical judgements. Occupational therapists in the present research concurred that experts differed from novices in the extent to which experts preferred to rely on their experience and knowledge of measurement principles, in contrast to novices who preferred to rely on standardised FCEs. A clearly enunciated principle of occupational therapy professional reasoning and decision making (or clinical reasoning style) in the medico-legal system was to closely examine the consistency between the sources and types of information gathered (e.g., in-rooms and workplace assessments, observation and client self-report). However, the current findings did not support an understanding of expertise based solely on years of experience, and highlighted that three additional issues need to be considered. These issues were: (a) the type of relevant experience, especially vocational or occupational rehabilitation experience; (b) the nature of the question asked of the expert; and (c) the recency of the expert’s experience and knowledge. Another important difference between the present findings and that of Benner et al. (1996) is that medico-legal experts developed their opinions independently of the claimants.

In the past decade the nature of clinical expertise or mastery in the health and rehabilitation professions has been the subject of examination and theory development (Craik & McKay, 2003; Gwyer, Jensen, Hack & Shephard, 2004; Jensen, Gwyer, Shepherd, Hack, 2000; Higgs & Jones, 2000; Higgs & Bithell, 2001; Madill & Hollis, 2003; Resnik & Jensen, 2003; Tonelli, 1999). This body of literature has focussed on service provision of occupational therapists and physiotherapists, principally in hospital or clinical settings. Clinical expertise has been associated with a number of factors,
several of which were supported by the present research. These factors include the following: (a) applying intuition to deep tacit knowledge without needing to rely on rules or guidelines (Craik & McKay, 2003); (b) being at the pinnacle of their profession in terms of skills, knowledge, judgement and performance (Craik & McKay, 2003; Higgs & Bithell, 2001); (c) having academic credentials (and teaching experience) (Craik & McKay, 2003; Madill & Hollis, 2003); (d) having specialised training (Higgs & Bithell, 2001); (e) having years of experience (Benner, 1994; Higgs & Bithell, 2001; Jensen et al, 2000); (f) producing better outcomes for clients (Resnik & Jensen, 2003); (g) valuing the collaboration of clients, care-givers and team members in the decision-making process (Higgs & Jones, 2000); (h) communicating reasoning in a way that is clear and appropriate to the audience (Higgs & Jones, 2000); and (i) having superior interpersonal and communication skills (Higgs & Bithell, 2001). Despite the recent examination and advances in theory development within the health and rehabilitation professions, Tonelli (1999), a medical academic, suggested that expertise as a concept had been poorly articulated and insufficiently researched in relation to evidence based medicine, and this partly explained why it was relegated to the lowest rung on the evidentiary ladder (NHMRC, 1995; Sackett et al., 1996, 2000). The work of Jensen et al. (2000) is among the limited examples of research to examine and articulate expertise in the health and rehabilitation professions.

Jensen et al. (2000) undertook extensive qualitative research to develop a theoretical model of expert clinical practice in physiotherapy. They found that experts had in excess of 7 years’ clinical experience and that the core dimensions of expert practice in physiotherapy centred around a philosophy of physical therapy practice with a central focus on functional movement. This expertise was supported by knowledge that was multidimensional and client-centred, clinical reasoning based on collaboration
with patients and their families and self-reflection, and the virtues of caring and commitment.

Therefore authors in the health and rehabilitation professions have examined the nature of expertise in clinical practice where the management of the therapist-client relationship is perceived as a major component of expertise. However, consultants, such as occupational therapists who provide independent expert opinions on work capacity, have several interested and competing stakeholders, only one of whom is the client. Therefore, the meaning of expertise for consultant occupational therapists needs to be conceptualised differently as theoretical frameworks relevant to therapist-patient relationships in clinical settings can not adequately explain expertise in the medico-legal system or depict the complexities of providing expert opinions on work capacity. The grounded theory of expertise in work capacity identified in the present research is consistent with the five legal rules of expert evidence (Freckelton & Selby, 2002). These rules relate to the recognising an expert through their distinctive knowledge, experience, credibility, and scope of opinion evidence they can offer the courts.

In the present research, the clarification of the nature of occupational therapy expertise as a consultant in the medico-legal system advances theoretical frameworks of expertise in the health and rehabilitation professions. The theory of expertise in this thesis differs from earlier work on expertise in two main respects. First, the interactions with clients are de-emphasised, while the process of forming opinions independently without collaboration with the client, the client’s family, and professional colleagues is emphasised. The second difference is the expert’s ability to reason about the client’s future work performance and work participation. The expert occupational therapist uses predictive reasoning to envision the clients’ future outcomes (Fleming, 1994; Higgs et al., 1999). Weiss and Shanteau (2003) identified that predictive experts have the challenge of incorporating evaluation of the relevant aspects of a situation into a
projected future scenario. They must anticipate any changes that may influence outcomes. Indeed, the current research extends the understanding of predictive reasoning by highlighting the value to a number of stakeholders of occupational therapists (and other expert witnesses) being able to accurately predict the workforce participation of claimants, and thus influence medico-legal decisions. This kind of occupational therapy reasoning extends beyond the reasoning applied to outcomes of rehabilitation interventions in terms of functional daily living activities including work tasks. Predictive reasoning regarding work performance and work participation, supported by experience and a rationale, renders the experts’ opinions more legally useful.

A number of approaches have been employed to investigate experts including those in the areas of judgment and decision-making, and cognitive science (Shanteau, 1992). In contrast to the health and rehabilitation literature, research on judgement and decision making of experts generally concluded that experts can be inaccurate, unreliable and biased (Shanteau, 1992). This view would appear to be shared by participants in the present research who (a) may have disagreed with occupational therapy expert opinions that claimants were unemployable, (b) indicated that experts’ opinions often differed, or (c) expressed concern that bias was a persistent problem associated with experts. Using a cognitive science approach, R. Glaser and Chi (1988) identified seven generic characteristics of expertise. Compatible with the findings of the present research, R. Glaser and Chi identified that experts excel in their areas of expertise, have principles that assist them to represent the presenting problems, and analyse problems qualitatively. In addition, R. Glaser and Chi identified some aspects of the cognitive style of experts (e.g., rapid processing with few errors, superior short and long-term memory) that were not found in the current research. The judgement and decision-making and cognitive science approaches to researching experts differ from
the current research in one other important respect. The grounded theory of expertise was socially constructed. Socially-constructed theories about professional expertise “have meaning within the context in which they are used, and meanings change as societal values and beliefs evolve” (Higgs & Bithell, 2001, p. 59).

In conclusion, the grounded theory derived from the views of three groups of practitioners with direct and recent experience of occupational therapists’ contribution to medico-legal decisions about work capacity, has extended and updated previous literature on the topic. Furthermore, it is anticipated that the grounded theory of expertise will advance the inter-professional literature on theories of expertise in the medico-legal system including expert professional reasoning and decision-making. B. Glaser (1999) emphasised that the advantages of grounded theory research is that it yields research “that fits, works, is relevant, and is readily modifiable” (p. 841). The development of the grounded theory is compatible with Driver’s (1968) view that professional knowledge must be advanced through critical scientific examination and reinforces the views of Stanley and Cheek (2003) that grounded theory methodology can lead to theory development in occupational therapy.

10.3 Research Limitations and Methodological Considerations

A number of research limitations and methodological considerations need to be taken into account when interpreting the present findings. The ways in which they were considered and addressed in the research are now described.

Four limitations have been associated with obtaining interview data from participants. First, in research interviews the participants’ perception of the research and of the researcher may determine what information is shared and what is withheld (Gillham, 2000). In this research, efforts were made to establish trust and rapport so that participants would feel encouraged to openly share relevant information that had
not previously been accessible for professional or research purposes. The researcher aimed to appeal to the participants through focussing on the potential value of the aggregated data to improve the contribution of occupational therapists to the medico-legal system. The quantity of data and diversity of views expressed about the research topic indicated to the researcher that this aim was largely achieved. Second, semantic variations can lead to misunderstandings between the researcher and the participant and need to be clarified through the use of probes (Gillham, 2000). For example, words such as “psychosocial” and “medico-legal” have variations in meanings which the researcher probed during interviews and considered in the interpretation of the findings. Third, what people say they do may differ from what they would be observed doing (Britten, 1999). Similarly, interpretations about the same events can vary between participants. Fourth, accurate recall of facts can be a problem with the collection of retrospective data (Ludwig, 1998). This may result in omissions, and reinterpretation of experiences, perceptions and meaning as participants are required to reconstructed them (Ludwig, 1998). However, with respect to the third and fourth potential limitations of interview data, Minichiello et al. (1996) reminded researchers that the purpose of interpretative research is not to find the truth per se but to find the truth as each of the participants see it. It is their perceptions that guide their behaviours in social situations. Verification of the key findings by participants with diverse views enabled the researcher to minimise the limitations associated with interview data by gaining a high level of agreement on key findings and modifying others based on feedback.

As participants in qualitative research can choose to discuss experiences and perceptions of importance to them within the parameters of the topic, participants of this research responded in various ways to the open-ended interview cues and probes. The tables in this thesis and the variety of responses within them served to indicate the range of topics raised by participants. As each participant did not address all topics, the
numbers in the tables may not fully reflect the extent of agreement or disagreement among participant groups regarding these issues. Similarly, although the key findings needed only minor modifications to reflect the views of the 64.5% of participants who responded, during the verification process the views of the remaining 35.5% of participants who did not respond may not be fully reflected. Nevertheless, in keeping with a qualitative approach, the data presented in the four results and discussion chapters reflect the breadth and intensity of the perceptions and experiences of 31 participants. The diverse perspectives and unique experiences gathered from 19 occupational therapists and smaller numbers of medical specialists and lawyers are particularly valuable to this research as the in-depth interviews provided data not previously recorded in the literature.

A criticism of qualitative research is the subjective nature of the data (Pope & Mays, 1999). Even the labelling of themes or categories is, to some extent, subjective (Gillham, 2000). In spite of this limitation, complete detachment of the researcher is not an advantage in qualitative research (Fitzgerald, 2001), as it can reduce the depth and richness of the data gained from interviews. On the other hand, grounded theorists have been criticised for their association with the positivist tradition, overemphasising reliable and rigorous data and under-emphasising the role of the researcher (Grbich, 2004). To maintain an appropriate balance between these two limitations, the researcher was guided by Strauss and Corbin (1998) and aimed to balance sensitivity and objectivity, and be creative and impartial simultaneously. The researcher took into account the possible negative effects of subjectivity and used strategies to limit them (see section 3.7.2). In addition, the monitoring of data analysis by three experienced researchers contributed to these balancing strategies.

All grounded theories are acknowledged to have two limitations (Strauss & Corbin, 1994). First, they must be regarded as provisional, and allow for further
elaboration and qualification. Second, grounded theories may be limited by time, and the broader legal, social and political contexts. For example, a large majority of the participants were Australian. As circumstances relating to these contexts change, some aspects of the theory will need modification. In particular, the status of any theory remains provisional until evaluated on a larger scale over a period of time (B. Glaser & Strauss, 1967).

In some situations, occupational therapists commence their assessment of work capacity with global assessments of function in ADL assessments. Although the researcher was careful to ask participants to limit their comments to expert opinions on work capacity rather than ADL through the Participant Information sheet (see Appendix B), Interview Guides (see Appendices E and F) and interview probes, it may have been difficult for participants to fully separate these roles in some instances. Distinguishing between the two major areas of occupational therapy expert opinions was considered important in this research as the claimant’s economic loss is considered separately from his/her gratuitous care and assistance claim in personal injury cases. Even so, it is unclear the extent to which some of the findings may also apply to occupational therapy experts who assess both ADL and work capacity. On the assumption that the present findings, relating to economic loss, do not specifically apply to occupational therapy medico-legal assessments for gratuitous care and assistance claims, this related area of practice warrants further investigation.

The views of claimants/plaintiffs and employers were not sought for this thesis. Their perspectives may have assisted the researcher to refine the grounded theory. However, apart from resource limitations preventing the inclusion of groups of claimants and employers, the researcher considered that accessing members of the legal professions who represent and advocate for these groups in the medico-legal system enabled her to indirectly obtain their perspectives. In addition, a pilot study revealed
that accessing claimants after settlement was practically difficult and posed ethical problems (Allen, Deacon, Slatter, Rainwater, & Newbold, 2003). Furthermore, an Amendment to the (Commonwealth) Privacy Act of 1988 (2000), further restricted access to this group through the private sector when it came into effect in December 2001.

Half of the occupational therapy participants identified that they assessed claimants with TBI in the medico-legal system, making this the second largest claimant group assessed. While occupational therapy literature has supported this role (Bootes & Chapparo, 2002; Radomski, 2001; V. J. Rice & Luster, 2002), only two of the lawyers and one of the medical specialists referred to this or other specialised areas of occupational therapy medico-legal practice. Hence, the perceptions and experiences of occupational therapists’ contribution with regard to TBI and other specialised areas of medico-legal practice could not be adequately verified. Neurologists, neurosurgeons and neuropsychologists would be appropriate groups of participants to interview to verify occupational therapists’ medico-legal role with clients with TBI. This highlights an area for future research.

The relevance and application of findings of qualitative research have typically been confined to the participants of the study. Customarily, the aim of the qualitative research paradigm is a full and sophisticated understanding of all aspects of a phenomenon rather than confident generalisation to a population of which the sample was representative (P. L. Rice & Ezzy, 1999). The generalisability of qualitative research findings to wider populations has been questioned because it is not based on statistical sampling methods and a normal distribution, or statistical techniques that are based on probability theory (Gerber & Moyle, 2004; P. L. Rice & Ezzy, 1999). A related reason is that the context of the social phenomenon may be too complex to allow generalisations to be made from one situation to another. However, this limitation
in the application of qualitative research findings has itself been questioned (Fitzgerald, 2001; Gerber & Moyle, 2004; Morse, 1999; Taber, 2000). These authors proposed that it may be possible to describe the essential features of a context in such a way as to permit the reader to determine whether the research findings are applicable to their own context or to be able to judge points of dissimilarity. Fitzgerald (2001) reasoned that generalisability depended on factors such as the “research question, the nature of the data, the source of the data, [and] the nature of the conclusions” (p. 186). Similarly, Morse (1999) stated that provided the sample is purposefully selected and the theory is “comprehensive, complete, saturated, and accounts for negative cases,” then the knowledge from the theory should fit similar scenarios identified in a larger population (p. 5). Taber (2000) made a distinction between the traditional normative meaning of statistical generalisation and analytical generalisation in which the onus is on the readers to make a reasoned judgement about how a study may guide them in another situation. In this research, limitations associated with statistical generalisability are accepted. However, the points made by Fitzgerald (2001), Morse (1999), and Taber (2000) can be applied. With respect to these methodological considerations, the researcher has provided detailed descriptions of those aspects of the research (e.g., the medico-legal system, the participants) to enable readers to determine the relevance and applicability of the grounded theory to their own situation, especially the representativeness of the concepts (Strauss & Corbin, 1998). Therefore, if the representativeness of concepts in the grounded theory of occupational therapy expertise in work capacity is understood, it is expected that readers can judge its relevance and applicability to similar medico-legal consultancy contexts.
10.4 Implications for the Occupational Therapy Medico-legal Specialty: Understanding and Developing Expertise

The major findings of the research have a number of implications for occupational therapy practice in the medico-legal speciality. The grounded theory of expertise in work capacity suggests that there are four important areas on which practitioners should focus.

First, an understanding of the medico-legal system and relevant interactions with stakeholders is essential to occupational therapists in work rehabilitation and those who specialise in medico-legal consultancies. An understanding of the perspectives and roles of the key medico-legal stakeholders would enable occupational therapists to respond more confidently and appropriately to requests for them to conduct assessments and provide reports with return-to-work recommendations. Second, occupational therapists would benefit from being informed about their areas of expertise recognised by the courts and those of other medical, rehabilitation and vocational experts. Their practice is likely to be enhanced by understanding the value of their expertise in work performance and work participation in the medico-legal system. Third, it would be an advantage to occupational therapists to know how their professional credibility can be increased through gaining experience and relevant competencies, and lessened through perceptions of bias and inadequate assessment and reporting practices. Fourth, occupational therapy expert opinions about the claimants’ potential work participation are likely to be further enhanced by understanding the importance of utilising their relevant experience and knowledge and applying predictive reasoning to their findings about the claimants’ work performance. Predictive reasoning about work participation is encouraged by the courts as future economic loss is a major component of personal injury claims, and occupational
therapists’ expertise in work capacity is often required in those cases where no
straightforward answers or standards exist.

It is important that if occupational therapists continue to apply predominantly
qualitative research principles to their work capacity assessments and opinions that
they clarify how the relevant research principles increase the defensibility of their
assessment methodologies in the medico-legal system. In order to address the
preference of the medico-legal system for some psychosocial assessments to be
provided by other experts, it would be advantageous to more explicitly incorporate
occupational therapists’ unique perspective on the impact of psychosocial factors on
work capacity into their assessments. There is ample support for the continuation of the
occupational therapy practice of providing valid assessments by relating the work
capacity of the person to relevant workplaces and work environments. Similarly, there
is support for occupational therapists continuing to provide reports on the practical
implications of personal injuries based on substantial periods of observation,
demonstrating their reasoning about the consistency of the claimant’s performance and
expressing their opinions as clearly as possible in lay terms.

Finally, the present study enabled the researcher to develop a framework for
enhancing medico-legal opinions. The framework has a number of guidelines for
practice and includes recommendations for organisations such as universities,
professional associations and registration boards that have responsibility for addressing
occupational therapy professional issues including training and education, ethical
practices and accreditation of practitioners. The framework has a number of other
practice guidelines for occupational therapists’ individual assessment and reporting
practices. Overall, these findings appear to be the first set of recommendations for the
education and training needs of occupational therapists who provide expert opinions on
work capacity. The framework includes some strategies that individuals can enact
independently. Participants extended the limited information on the medico-legal speciality available in undergraduate work practices curricula (Burwash, 1999; Jacobs, 1991a). The framework provides a guide for the design and delivery of a post-graduate education module that was previously lacking in the occupational therapy literature.

The researcher has begun to communicate the research findings through a series of presentations, papers, and planned workshops. It is anticipated that communicating the findings to practitioners will enhance the ongoing contribution of occupational therapists to medico-legal decisions about work capacity.

10.5 Recommendations for Further Research

The research has opened up several new areas of research. Seven areas of research that are likely to provide useful results are proposed.

1. The first proposed area of research is to extent the verification of the current research findings. This research would entail a content analysis of common/case law decisions in Australian jurisdictions to which occupational therapists have contributed an expert opinion on work capacity. Such research would permit a thorough examination of the extent of occupational therapy contribution to work capacity decisions throughout Australia from the perspectives of the judiciary as recorded in official legal documents.

2. Further research is required to extend the usefulness of the grounded theory of expertise. Through the exploration of this phenomenon in a range of contexts and situations, a substantive grounded theory developed in one context evolves towards a formal theory with more general application (B. Glaser & Strauss, 1967).

Research in similar and different circumstances (e.g., medico-legal systems in other states of Australia, the U.K., Canada and the U.S. with similar participant groups) may result in the theory being extended, modified, or qualified.
3. An exploration of the perspectives of claimants would provide another opportunity to extend the theory of expertise. In particular, claimants’ perceptions and experiences of the accuracy of occupational therapy expert opinions in predicting their work participation would enable occupational therapists to refine their professional reasoning regarding this essential and challenging part of their role as experts. From an appreciate inquiry into the claimants who successfully returned to paid employment despite impairments, it would be possible to gain further insights into physical and psychosocial influences on their work participation.

4. The development and evaluation of a continuing professional education program to enhance the professional reasoning and decision-making of occupational therapists are indicated. The program could include a number of strategies recommended by participants such as ways to form opinions in the medico-legal system, while evaluation could focus on how training facilitated the accuracy of occupational therapy predictions about workforce participation.

5. A study of the contribution of occupational therapy expert opinions to decisions about gratuitous care and assistance would be useful. These cases following the precedent of *Griffith v. Kerkemeyer* (1997) are the other major area of occupational therapy contribution as medico-legal experts, the importance of which were referred to by several occupational therapists in the research.

6. Closer examination of ways in which occupational therapists can apply their knowledge of psychosocial and cognitive impairment to understandings of workforce participation is required. Such research could be undertaken in collaboration with relevant medical specialists and neuropsychologists.

7. Finally, an area of research that has potential application to health professionals more generally is the area of expertise in consultancies. Such research would add to the existing body of research on clinical expertise.
10.6 Final Comment

This research into the contribution of occupational therapists to medico-legal decisions about work capacity has identified a grounded theory of occupational therapy expertise in work capacity. The concluding chapter highlighted the implications of the findings for future occupational therapy practice, professional development and research. It is anticipated that the implementation of knowledge and strategies related to the findings in these areas will ensure that occupational therapists have practice guidelines, a postgraduate education module, and research evidence to enhance their on-going contribution to medico-legal decisions about work capacity.
References


Cochrane Library. Accessed April 9, 2005 at [www.cochrane.org/cochrane.co.uk/](http://www.cochrane.org/cochrane.co.uk/)


*Occupational therapy and physical dysfunction: Principles, skills and practice* 

Federal Court of Australia. (2004). *Guidelines for expert witnesses in proceedings in* 
*the Federal Court of Australia.* Retrieved November 12, 2005 from 

Fenton, S., Gagnon, P., & Pitts, D. G. (2003). Interventions to promote participation: 
Work. In E. B. Crepeau, E. S. Cohn, & B. A. Boyt Schell (Eds.), *Willard and* 
*Spackman’s occupational therapy* (10th ed., pp. 555-561). Philadelphia: 
Lippincott, Williams & Wilkins.

Melbourne: Longman.

Finlay, L. (2000). Multiple voices, multiple paths: Choosing between qualitative 

Fishbain, D. A., Abdel-Moty, E., Cutler, R., Khalil, T. M., Sadek, S., Steele-
capacity in chronic low back pain patients based on the Dictionary of 
Occupational Titles. *Spine, 19*(8), 872-880.

Fishbain, D. A., Cutler, R. B., Rosomoff, H. L., Khalil, T. M., Abdel-Moty, E., & 

there a relationship between non-organic physical findings (Waddell Signs) and 


Glaser, B. G. (1999). The future of grounded theory. [Keynote address from the fourth annual qualitative health research conference]. *Qualitative Health Research, 9*(6), 836-845.


National Health and Medical Research Council (NHMRC) (1995). *Guidelines for the development and implementation of clinical practice guidelines.* Canberra, Australia: NHMRC.


Legislation


http://www.bailii.org/uk/legis/num_act/dda1995264/notes.html


APPENDICES

Appendix A: Glossary of Medico-legal and Professional Terms
Appendix B: Participant Information Sheet
Appendix C: Informed Consent Form
Appendix D: Gate Keeper Letter
Appendix E: Interview Guide for Participant Occupational Therapists
Appendix F: Interview Guide for Participant Medical and Legal Professionals
Appendix G: Pro forma for Part 1 of In-depth Interviews
Appendix H: List of Open Codes
Appendix I: List of Participants’ Pseudonyms according to their Professions
Appendices J: Participant Verification Package including Key Findings.
   J1 Letter dated February 17, 2004
   J2 Letter dated January 5, 2005
   J3 Questions for Participants about Key Findings
   J4 Overview of the Contribution of Occupational Therapists to Medico-legal Decisions about Work Capacity
   J5 Four Clusters of Key Findings
Appendix K: Sample FCE Format based on the Dictionary of Occupational Titles (1991b)
Appendix A: Glossary of Medico-legal and Professional Terms

The following glossary defines or explains terms that have been used throughout the thesis.

**Abnormal Illness Behaviour or Symptom Magnification Syndrome:** This term has been applied in some situations in which claimant’s perceived disability exceeds the objective medical pathology expected from an injury. Previously used descriptions include malingering, secondary gain, functional overlay, non-organic pain, hysterical neurosis (see Mueller et al., 1997, p. 494) (see also Malingering).

**Adjudication:** “A judgement or decision of the court” (Occupational Therapy Australia - New South Wales, 1998, p. 37).

**Advocate:** One who pleads the cause of another in a judicial tribunal; barristers or solicitors (Occupational Therapy Australia - New South Wales, 1998, p. 37).

**AMA guides:** This is the abbreviated term for the American Medical Association’s Guides to the evaluation of permanent impairment (5th ed.), edited by Cocchiarella and Andersson (2001). It has widespread acceptance and use in medico-legal systems in the U.S. and Australia.

**Appeal:** A request before a higher court to hear arguments for reviewing and reversing a decision of the lower court on the basis that it was erroneous (Gifis, 1991; Occupational Therapy Australia - New South Wales, 1998).

**Barrister:** “A class of legal practitioner who is by law and custom limited to advocacy and advisory work, in any field of law. Also known as ‘counsel’ ” (Nygh, Butt, & Clark, 1998, p. 12). “A solicitor admitted to the Bar” (Occupational Therapy Australia - New South Wales, 1998, p. 37). He/she should be a specialist in a topic such as injury to the spine (Braithwaite, 1997). Queens’ Counsel and Senior Counsel are barristers.

**Bias:** “Prejudice; partiality; a lack of disinterestedness” (Nygh et al., 1998, p. 13).

**Civil Law:** Civil law involves actions taken by a citizen against another citizen. This is in contrast to criminal law in which the actions are taken by the State against a person alleged to have committed a crime (Forrester & Griffiths, 2001). In civil cases the standard of proof is “on the balance of probabilities,” while in criminal cases the standard is “beyond reasonable doubt” (Forrester & Griffiths, 2001, p. 9).

**Claim:** Also known as an “action” or “matter.” “The assertion of a right … to a remedy, … the grounds in pleadings upon which relief is claimed” (Nygh et al, 1998, p. 18).

**Claimant:** A general term for a person who claims entitlements or otherwise seeks redress under common or statutory law. This term includes the more specific term plaintiff (cf. Plaintiff).

**Common Law:** Legal records consisting of decisions about the common way for people to behave towards each other in disputed cases. English common law mainly...
revolves around negligence that has been simply defined as a “failure to act with a reasonable degree of prudence, with regard to reasonably foreseeable danger” (Pheasant, 1991, p. 22). “The unwritten law derived from the tradition of England as developed by judicial precedence, interpretation, expansion and modification” (Nygh et al., 1998, p. 18-19). Law made by judge/s as opposed to legislative or administrative regulation (Nygh et al., 1998, p. 50).

**Compensation:** “An amount given or received as recompense for a loss suffered” (Nygh et al., 1998, p. 19) (see also Damages).

**Continuing Professional Education:** Education of graduates in topics of relevance to professional practice. Continuing education is usually arranged through a professional association as a seminar or workshop. Fees are paid. The education is not credited towards a higher degree, though may be used for professional accreditation.

**Counsel:** “A person who appears as an advocate before a court” (Nygh et al., 1998, p. 22).

**Court:** “1. A place where justice is administered. 2. The decision maker (makers) who sits in a court” (Nygh et al., 1998, p. 23). “The term ‘court’ refers to a court (which may be a judge sitting alone or a judge and jury), a tribunal or any other forum where formal rules of evidence apply” (Australian Medical Association, 1997, p. 1). In Australia, occupational therapy expert witnesses provide opinions on work capacity in a court or tribunal without a jury.

**Criterion-referenced Assessments:** These assessments are designed to determine whether the person can perform certain tasks to a criterion rather than be compared to others on a normal distribution. Criteria are described in terms of desired standards of performance outcomes (Ottenbacher & Christiansen, 1997). For example, Valpar component work samples are criterion-referenced assessments of work activities that have similar tasks, materials and tools to those in a number of actual jobs or occupations (Mueller et al., 1997). Criterion-related validity of FCEs or work capacity assessments aims to ensure assessments are predictive of work participation or significantly correlated with critical work activities.

**Cross-examination:** Questions addressed to a witness by a party other than the party who called the witness to give evidence (Nygh et al., 1998, p. 23). Cross-examination takes place between examination and re-examination of an expert witness when experts are addressed questions by the party who called the witness.

**Damages:** “Compensation for damage suffered; a court awarded sum of money which places the plaintiff in the position he or she would have occupied had the legal wrong not occurred” (Nygh et al., 1998, p. 24). General damages relate to the future, and special damages relate to the past (Braithwaite, 1997).

**Defendant:** “The person said by the plaintiff to be responsible for the injury” (Braithwaite, 1997, p. 15).

**Deposition:** A U.S. legal term. “A deposition is a formal meeting at which attorneys representing the parties to a law-suit will ask the witness, also known as the deponent, a
series of questions.” The deponent, who is under oath, may act as factual or expert witnesses and must respond to the questions (Ekelman Ranke, 1997, p. 754)

**District Court:** “A State or Territory court of general jurisdiction in the jurisdictions of New South Wales, Queensland, and Western Australia, which in the hierarchy of courts is below the Supreme Court of the jurisdiction but above ... local courts” (Nygh et al., 1998, p. 25). County Courts are the equivalent courts in Victoria.

**Employability:** The participants’ term for the claimant having the work capacity to participate in paid employment in the national economy, despite impairment. It includes factors contributing to the extent of labour market disadvantage such as an inability to work pre-injury hours, and having access to jobs matching the skills, abilities and interests of the claimant.

**Evidence:** “Any statement, record, testimony, or other things, apart from legal submissions, which tends to prove the existence of a fact in issue” (Nygh et al., 1998, p. 30).

**Examination in chief:** “Questioning of a witness by a party who called that witness” (Nygh et al., 1998, p. 30).

**Expert Witness:** “An expert witness is a person who is called, or is to be called, by a party to give opinion evidence, based on the person’s specialised knowledge, or based on the person’s specialised training study or experience” (Freckelton & Selby, 2000, p. 702). “An expert witness may express opinions upon relevant matters within the field of expertise; this is an exception to the general rule that a witness may speak only as to the facts” (Nygh et al., 1998, p. 31-32). The court decides whether the witness is qualified to be considered an expert (Occupational Therapy Australia – New South Wales, 1998). An expert witness is “one who by reason of education or specialised experience possesses superior knowledge respecting a subject about which persons having no particular training are incapable of forming an accurate opinion or deducing correct conclusions” (Black’s Law Dictionary, 1990, p. 578).

**Expertise:** “The quality or state of being expert” as reflected in an “expert's appraisal, valuation, or report;” “skill or expertness in a particular branch of study” (Oxford English Dictionary, 1989).

**Function:** The participants’ term for the ability to perform work and other daily living tasks or activities, despite impairment. The ability of a person to perform the daily life tasks related to ADL, IADL (instrumental activities of daily living), work, play and leisure and that he/she wants or needs to be able to perform (Fisher, 1994). Several occupational therapy authors have replaced the term “function” with “occupational performance” to differentiate occupational therapists’ contribution from that of several other health professions who use the word in different ways (Fisher, 1994; Law et al, 1996; Moyers, 1999). For occupational therapists, the concept of function focuses on performance in a person’s occupational roles (Law & Baum, 2001; Reed & Sanderson, 1999). “Occupational performance” is the point at which the person, the environment and the person’s occupation intersect to support the tasks, activities, and roles that are unique to an individual (Baum & Law, 2001; Law et al., 1996) (see also Functional Capacity).
**Functional Capacity**: A general term used by occupational therapists to mean the ability to perform essential ADL, IADL, work and leisure domains of life. The terms “functional capacity”, “activities of daily living,” and “occupational performance” may be used interchangeably in the occupational therapy literature. (cf. Work Capacity). Functional Capacity Evaluation may also be used to refer to a range of assessments used to assess a person’s abilities to perform the physical demands of work, based on the DOT (see also Work Capacity).

**Insurer**: In the rehabilitation literature, the role of injury/disability insurers is providing a measure of financial security to injured workers who qualify for payment (Reineke Lyth, 2000). In the medico-legal literature, insurers assess claims to determine liability based on the advice of investigators and independent medical assessors (Ellis, 2001), and are referred to as a source of defendant referrals (Breen et al., 1997). Although in theory an action is taken against an employer or other party at fault, in practice it is the insurer against whom claims are brought and who contests them (Dix et al., 1996). Insurers and defendant solicitors representing them aim to reduce the settlement awarded to the claimant (Sterry, 1998). Insurers employ injury management consultants/rehabilitation advisors to advise them on cost-effective methods to return the claimant to work.

**Job**: A job is a set of tasks designed to be performed by one person in return for a wage or salary. A set of jobs with similar tasks is an occupation such as truck driver (Australian Standard Classification of Occupations, 1997).

**Job Analysis**: “Systematic evaluation of a job. A physical evaluation of a job site, observing workers performing the tasks, measuring equipment, and equipment placement, reviewing job-related documents such as job descriptions, and interviewing those who perform the job and their supervisors (V. J. Rice & Luster, 2002, p. 716).

**Judge**: “A person invested with the authority to determine matters requiring the application of a legal remedy (such as the adjudication of a dispute between parties)” (Nygh et al., 1998, p. 50). In civil cases a judge has the power to award damages.

**Judgement**: The final decision or determination of the court in legal proceedings including payment of an amount of money and costs (Gifis, 1991; Nygh et al., 1998).

**Jurisdiction**: “The scope of the court’s power to examine and determine the facts, interpret and apply the law, make orders and declare judgement. Jurisdiction may be limited by geographic area, the type of parties who appear, the type of relief that can be sought, and the point to be decided” (Nygh et al., 1998, p. 51).

**Legislation**: Acts, or statues, adopted by Federal or State Parliaments. Together with regulations drawn up by powers conferred by legislation, they constitute the law.

**Liability**: The extent to which a party is responsible for an accident (Braithwaite, 1997).

**Malingering**: The intentional presentation of false or exaggerated physical or psychological symptoms motivated by external goals such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs (American Psychiatric Association, 2000) (see also Abnormal Illness Behaviour).
Mediation and Conciliation: Terms used for compulsory pre-litigation or pre-court process in some jurisdictions. Mediation involves the two parties attempting to settle a dispute with the assistance of a neutral third party with no advisory or determinative role. Conciliation is a similar process, but the conciliator may have an advisory role (i.e., make suggestions, give expert advice and actively encourage participants to reach an agreement) (Department of Justice and Attorney General - Queensland, 2003).

Medico-legal: The term medico-legal may be used to describe the generic contribution of the medical, health and psychological professions to the legal context. Sometimes referred to as “medical-legal” (Burwash, 1999). Medico-legal reports are used for litigation, compensation and insurance purposes. “A medico-legal report is one prepared by an independent consultant following a comprehensive assessment of the client to provide an opinion which is used in the legal process. The consultant has generally not been involved with the client’s treatment. Their role is to objectively assess the client’s functional status and identify their future needs” (Occupational Therapy Australia - New South Wales, 1998, p. 3).

Non-standardised FCEs: The term refers to individualised assessments using methods consistent with qualitative research inquiry such as semi-structured interview, extended periods of observation, triangulation of sources of information, and conveying information in words and pictures rather than numbers, member checking, and reflection on the meaning of the information (Innes & Straker, 2002b). Ottenbacher and Christiansen (1997) described non-standardised assessments as individually and intuitively developed assessments in which the items, methods of administration and interpretation are not always clearly defined or systematically evaluated, and whose value varies with the practitioner’s theoretical understanding and experience (cf. Standardised FCEs).

Norm-referenced Assessments: Assessments in which an individual’s performance is “compared and/or ranked relative to a broad typical sample to which the test has previously been administered (the normative sample)” (Ottenbacher & Christiansen, 1997, p. 116) (cf. Criterion-referenced assessments).

Objective: Observable, verifiable, impersonal, and impartial (cf. Subjective).

Occupation: “Occupation” may have two meaning when used by occupational therapists. 1. Occupation refers to engagement in meaningful activities in an environment, and so it has additional considerations to “function” or “activities of daily living.” Some occupational therapists prefer the term “occupation” to “function” to most closely reflect the profession’s uniqueness. 2. Occupation is a cluster of jobs such as teacher. The second use is consistent with lay use of the term.

Occupational Performance Testimony: Occupational performance testimony means presenting expert witness opinions, typically, in U.S. courts (see also Testimony).

Occupational Rehabilitation: “This is a managed process involving early intervention with appropriate, adequate and timely services based on assessed needs, which is aimed at maintaining injured or ill workers in, or returning them to, suitable employment” (National Occupational Health and Safety Commission, 1995, p. 2). The priority is to return the injured worker to the pre-injury job or modified job with the same employer.
The workplace is the preferred venue for occupational rehabilitation (cf. Vocational rehabilitation).

**Opinion:** Occupational therapy work-related opinions include statements about a claimant’s assessed work capacity and recommendations for increase it. An opinion is also a view held about a particular issue; a judgement formed or a conclusion reached, especially about a disputable point (Oxford English Dictionary, 1989). An opinion is a formal statement by a judge or other competent authority of what he or she judges or advises on a matter; professional advice, such as a legal or medical opinion. A second (also another) opinion is the opinion of a second (esp. medical) expert or adviser (Oxford English Dictionary, 1989). Opinion evidence is neither true nor false.

**Performance-based Assessments:** These assessments rely on professional observation and rating of client behaviours and activities in order to determine their ability to complete tasks according to verbal instructions (Ottenbacher & Christiansen, 1997) (cf. Self-assessments).

**Plaintiff:** A person who brings an action or complaint before the court or who sues the person cited as responsible for an injury to recover damages (Braithwaite, 1997; Gifis, 1991; Occupational Therapy Australia - New South Wales, 1998). (See also Claimant).

**Precedent:** “A judgement or decision of a court of law cited as an authority for deciding a similar set of facts” (Occupational Therapy Australia - New South Wales, 1998, p. 38).

**Prognosis:** A prognosis is a “prediction of the course and end of a disease, and an estimate of the chance for recovery” (Taber, 1997, p. 1568).

**Quantum:** “The amount of compensation which is appropriate in a particular case. It is divided into two distinct parts: first, pain, suffering and loss of amenity; and secondly, financial loss” (Braithwaite, 1997, p. 2).

**Quasi-judicial:** “A term used to describe the actions of non-judicial bodies, such as administrative agencies and tribunals, when they exercise their functions and powers in a judicial manner” (Nygh et al., 1998, p. 85).

**Queen’s Counsel (QC):** A barrister “learned in law” (Occupational Therapy Australia, 1998, p. 38). “A title or honorary rank bestowed on a barrister or legal practitioner practising in the style of a barrister.” (Nygh et al., 1998, p. 85). Also know as a ‘Silk’ or the replacement term in Australia, ‘Senior Counsel.’

**Reasonable:** Not going beyond limits of reason with respect to requests or expectations; not extravagant or excessive; moderate in price, inexpensive (Oxford English Dictionary, 1989).

**Reliability:** One of two primary measurement issues, the other being validity. Reliability is the degree of consistency in repeated measurements of a stable phenomenon whether taken by the same assessor at different time intervals, different assessors or compared to parallel measures (Ottenbacher & Christiansen, 1997).
Self-reported Assessments: These are “self-assessments completed by the client or by a trained interviewer who solicits verbal information regarding the ability to perform certain activities” (Ottenbacher & Christiansen, 1997, p. 116) (cf. Performance-based assessments).

Senior Counsel (SC): “A barrister is considered the ‘leader’ or ‘senior counsel’ when they are retained to conduct a case in court, and lead the ‘juniors’ instructed to appear with them” (Occupational Therapy Australia – New South Wales, 1998, p. 38). Previously known as “Queen’s Counsel.”


Settlement: The “compromise or resolution of a claim or dispute” (Nygh et al., 1998, p. 96).

Solicitor: “The class of legal practitioner, generally responsible for advising clients on legal matters, preparing legal documents, representing clients in summary matters, and instructing barristers in relation to more complex advocacy work” (Nygh et al., 1998, p. 97). The solicitor’s role is to gather all the evidence about those losses and changes and to put a monetary value on them. Plaintiff solicitors aim to get the maximum they can for the person with injury (Sterry, 1998).

Subjective: Personal perception of the meaning and context of an experience (Pratt, 1997). The pain experience is a subjective experience. It may be difficult to verify subjective information by other means (cf. Objective).

Standardised FCEs: The term refers to assessments consistent with quantitative research principles such as the use of standardised assessments, measurement, expressing findings in numeric format, and comparison with published norms (Innes & Straker, 2002b). Standardised assessments typically provide normative or criterion-referenced data as standards of comparison, and reliability and validity coefficients to guide decisions. They have a defined scope, specific documented procedures for administration, scoring, interpretation, documenting and communicating findings (Ottenbacher & Christiansen, 1997) (cf. Non-standardised FCEs).

Statutory Law: Statutory law is passed by an Act of Parliament (cf. common law). Legislation is referred to as statutes in the U.S.

Subpoena: A formally written legal order (Gifis, 1991). “A writ issued in an action or suit requiring the person to whom it is directed to be present at a specified place and time, and for a specific purpose under a penalty” (Occupational Therapy Australia, 1998, p. 38). Subpoenas may also apply to documents. If treating occupational therapists are subpoenaed they may be questioned about the client’s rehabilitation treatment and progress (Occupational Therapy Australia, 1998).

**Theory:** Based on the Oxford English Dictionary (1989), a theory is a system of ideas or statements of general principles held as an explanation or account of known or observed phenomena or a group of facts.

**Tort:** “A civil wrong distinguished from the law of contract, law of restitution, and the criminal law” (Nygh et al., 1998, p. 104). Each person has a civil duty to care for one’s neighbour: a tort (the French word for “wrong”) is a breach of that civil duty (Pheasant, 1991).

**Trial:** “A fact finding process, by which a court resolves disputed issues of fact presented by the parties and applies appropriate legal rules, culminating in a judgment” (Nygh et al., 1998, p. 105). The parties to a particular issue present evidence and facts for the court to decide the truth of the matter (Gifis, 1991).

**Tribunal:** In Australia “regulatory authorities or ‘tribunals’ are established at state and Federal level to determine matters on the administration of government. They have legal powers similar to those of a court but procedures are less formal, … rules of evidence are less strictly interpreted and required documentation is simpler” (Breen et al., 1997, p. 232).

**Validity:** One of two primary measurement issues, the other being reliability. Validity is the accuracy with which an assessment measures what it intends to measure (Ottenbacher & Christiansen, 1997). It is the most important consideration when selecting an assessment as it gives the scores meaning. Predictive validity is the extent to which a performance measure indicates a future outcome such as future work participation.

**Vocational Rehabilitation:** A comprehensive rehabilitation program that aims to return an injured worker to a suitable alternative job after injury resulting in loss of work capacity for the former job. An alternative job may mean a change of job title, duties and/or tasks. Vocational rehabilitation programs are frequently more resource intensive than occupational rehabilitation as they are typically use case management and multidisciplinary teams of treating professionals, and are associated with increased time and costs (cf. Occupational rehabilitation).

**Work Capacity:** Work capacity refers to the comprehensively assessed capacity of a person to perform a job or jobs in the open labour market. In addition to a range of objective measures of function and the assessment of the person’s ability to perform work-related tasks undertaken in an FCE (Fenton & Gagnon, 2003), work capacity may include assessment of how cognitive and psychosocial factors impact on work skills and abilities, simulated and workplace assessments of performance, and subjective information from the client combined with predictive reasoning about the anticipated outcome over a longer period of time with or without additional interventions. The term “work capacity” is compatible with occupational therapy models that encompass work performance and workforce participation (Sandqvist & Henriksson, 2004). Work capacity is contrasted with “functional capacity” which is a term used by occupational therapists to refer to several areas of daily performance and by several professionals to refer to the ability to perform physical demands of work, often using the DOT as a guide (cf. Functional capacity).
**Work Rehabilitation:** This is a generic term including both occupational rehabilitation and vocational rehabilitation.
PARTICIPANT INFORMATION SHEET

This letter is to invite you to participate in my research. I am conducting qualitative research into the contribution of the occupational therapy profession to legal judgements regarding work capacity. I aim to use the results to improve the tertiary education of occupational therapists working in work rehabilitation and to develop a model to assist their decision making. The data I obtain from interviews and document analysis will be made available to the 30 participants, consisting of approximately 15 occupational therapists, 10 members of the legal profession, and 5 medical practitioners. The study is part of a Doctorate of Philosophy being undertaken through the Occupational Therapy Department, at The University of Queensland.

Your experiences, and the experiences of other participants, in requesting, providing, or perusing occupational therapy reports on work capacity are a vital part of the research, as are your experiences in requesting or providing expert opinion regarding work capacity. To get a good understanding of your experiences an interview is required. Later you will be invited to a focus group to hear the aggregated results so far, and to assist clarify any categories and theory in the data. The interview and the focus group will each take up to one hour. If you agree, the interview will be tape-recorded so that your experiences are accurately recorded. The interview can be held at a place convenient to you. You may terminate your participation at any stage without it affecting your rights and or my responsibilities as a researcher. The confidentiality of information given will be respected through use of pseudonyms and removal of identifiers about people and organisations. Transcripts will be returned to participants for correction of inaccuracies and removal of identifiers before data entry. Transcripts will held in a secure place by the researcher.

This study has been cleared by one of the human ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council’s guidelines. If you would like to speak to an officer of the University not involved in the study, you may contact the Assistant Ethics Officer or Ethics Officer on 3365 4582 or 3365 3924.

You are free to discuss your participation and other aspects of this research with my research supervisor, Dr. Glenys Carlson on 07 – 3365 3012, or my associate supervisor Professor Jenny Strong, Head, Department of Occupational Therapy on 07-3365 2652.

If you agree to participate please sign the attached consent form and return it to me in the self-addressed and stamped envelope before the interview. I will then arrange a time for us to speak. Many thanks.

Yours sincerely,

Shelley Allen
Phone: 07 – 3365 3451     Fax: 07 - 33651622
Email: Shelley.Allen@mailbox.uq.edu.au
INFORMED CONSENT FORM

Researcher: Shelley Allen, Department of Occupational Therapy, University of Queensland
Project Title: Occupational Performance Testimony: Inquiry into Occupational Therapy Contribution to Legal Decision-Making regarding Work Capacity.

I, ..............................................................................................................

Contact Address, Email and/or Phone Number: ...........................................

..............................................................................................................

I authorise Shelley Allen to interview me as a participant in research into the contribution of occupational therapists to legal judgements about work capacity.

I understand the purpose of the research is to improve the tertiary education curriculum and practice of occupational therapists in work rehabilitation.

I have been asked to participate in this research and acknowledge:

1. The nature and purpose of the research have been explained to my satisfaction;
2. I give my consent to my participation in the research voluntarily and freely;
3. I understand that the aggregated results of groups of expert participants will be used for research purposes;
4. I understand individual participants, their employer and/or their clients will not be identified except where the information is already in the public domain;
5. I am free to withdraw my consent at any time, in which event my participation in the research study will immediately cease and any information obtained destroyed if requested by me;
6. I consent to being audio-taped during individual and/or focus group interview;
7. I understand that all material is kept securely and that any audio-taped material is destroyed after 5 years.

NAME:............................................................................................................

SIGNATURE...................................................................................................

DATE: .............
<table>
<thead>
<tr>
<th><strong>Researcher:</strong></th>
<th>Shelley Allen, Department of Occupational Therapy, The University of Queensland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Title:</strong></td>
<td>Qualitative Inquiry into Occupational Therapy Contribution to Legal Decision-Making regarding Work Capacity</td>
</tr>
</tbody>
</table>

**GATEKEEPER LETTER**

This letter is to acknowledge that as the appropriate person I give Shelley Allen permission to invite selected members of staff in this organisation to participate in her research.

Signed: ………………………………………………………………………………………………………

Position Title:………………………………………………………………………………………………

Organisation:………………………………………………………………………………………………

Date:……………………………………………………………………………………………………
Appendix E: Interview Guide for Participant Occupational Therapists

IN-DEPTH INTERVIEW GUIDE
FOR
PARTICIPANT OCCUPATIONAL THERAPISTS


Thank participant for time and expertise.
Any questions before commencing prepared interview questions?

See Appendix G for Pro forma for Part 1 of In-depth Interviews on which to record this data.

Obtain demographic data: name, current employment status, job title.
Preferred method of contact for receiving transcripts, invitation to focus group or otherwise e.g. to hear presentations, to read papers and thesis.
Record gender, age range.
Confirm that the participant has expertise and experiences in one or more of the following areas: providing or perusing occupational therapy reports or providing expert opinion regarding work capacity, or has knowledge of the relevant medico-legal processes or work legislation.
Note the period of involvement in area/s of expertise- past and current involvement.
Method of recruitment

Part 2: Details of Experiences.

Note: Based on Creswell (1998) grounded theory questions should be directed to finding out what were the experiences, what caused them, strategies used to cope, consequences, what broader context issues influenced their strategies?

Tell me about your experiences, as an occupational therapist, with regard to work capacity testimony.
What in your experience are the main issues for you in doing this work? How do these issues influence your contribution to work capacity judgements?

Expanded questions for occupational therapists: For which Courts/jurisdictions have you provided reports (e.g., Supreme Court, administrative appeals tribunal, Human Rights and Equal Opportunity Commission)? What has been the extent of your experience with each? In what ways are you able to distinguish between your experiences in each jurisdiction?
Have you provided expert opinions for the prosecution and/or defence? In what ways have these experiences been similar or different?
What legislation has been the basis of the testimony, e.g. case law, OH&S, DDA, Workcover Act?
What services have you provided in each case: assessment/s, rehabilitation program, out-of-court settlement consultation, expert opinion?
What specific assessments and interventions have you used? To what extent do you limit your expertise to functional physical capacity? What has been your experience of reporting on non-physical aspects of work capacity and employability?
At what stage of the client’s disability or injury have you provided each service?
Tell me more about your experiences from referral to giving expert opinion.
How would you rate your own performance/level of expertise during each stage?
What were your feelings and perceptions at each stage?
What were the easiest and most difficult aspects of the experiences? What were the aspects of which you felt most and least confident? What would the people around you have said about the way you managed through these experiences?
Was there a time when your experiences differed from that/those experiences?
To what extent did your previous UG or PG tertiary education prepare you for this/these experiences?
To what extent did your subsequent training and/or continuing education prepare you for your experiences?
What assistance, if any, was available to you throughout your experiences?
With hindsight, what education, training or assistance would you recommend be available for occupational therapists?
Are you aware of other occupational therapists providing work capacity testimony for the Courts? If so, to what extend have they had similar experiences?

Any further comments?

Questions to ask when returning transcript of participant’s experience:

What, if anything, needs to be changed to represent your experiences as an occupational therapist in relation to occupational performance testimony?
Are you satisfied that your identity and the identities of your clients and workplace have been adequately protected in the transcript? What, if anything, needs to change?
Appendix F: Interview Guide for Participant Medical and Legal Professionals

**IN-DEPTH INTERVIEW GUIDE FOR PARTICIPANTS WHO ARE MEMBERS OF LEGAL AND MEDICAL PROFESSIONALS**

**Part 1: Introduction, Rapport building, Demographic details and Overview of Experiences.**

Thank participant for time and expertise.
Any questions from participant before commencing prepared interview questions?
See Appendix G for Pro forma for Part 1 of In-depth Interviews on which to record this data.

Obtain demographic data: name, current employment status, job title.
Record gender, age range.
Preferred method of contact for receiving transcripts, invitation to focus group or otherwise e.g. to hear presentations, to read papers and thesis.
Confirm that the participant has expertise and experiences in one or more of the following areas: requesting, recommending or perusing occupational therapy reports, or requesting expert opinion regarding work capacity, or knowledge of the relevant medico-legal processes or work legislation.
Note the period of involvement in area/s of expertise- past and current involvement.
Method of recruitment

**Part 2: Details of Experiences**

Note: Based on Creswell (1998) grounded theory questions should be directed to finding out what were the experiences, what caused them, strategies used to cope, consequences, what broader context issues influenced their strategies?

Tell me about your experiences with regard to work capacity testimony by occupational therapists.

What, in your experience, are the main issues associated with occupational therapy work capacity testimony? How do these issues influence the contribution of occupational therapists to work capacity judgements?

**Expanded questions for legal and medical practitioners**: In which jurisdictions have you encountered occupational therapists’ reports e.g. Supreme Court, Administrative Appeals Tribunal, Human Rights and Equal Opportunity Commission? What has been the extent of your experience with each? What legislation has been the basis of the reports and testimony, e.g. case law, OH&S, DDA, Workcover Act (Q’ld)?
What occupational therapy services have been provided in each case—assessment/s, rehabilitation program, out-of-court settlement consultation, expert opinion?
At what stage of the client’s disability or injury has each service been provided?
Tell me more about your experiences with occupational therapy services from referral to settlement.
What specific assessments and interventions are you aware of through occupational therapists’ testimony? To what extent is their expert opinion related to functional physical capacity? What has been your experience of occupational therapy expertise in non-physical aspects of work capacity and employability?
How would you rate occupational therapy contribution to work capacity judgements overall? Please provide examples from judgements where appropriate. How would you rate occupational therapy knowledge of legal processes and legislation? How would you rate occupational therapy expertise demonstrated during each stage?
What have you found to be the most helpful aspects of occupational therapy contribution to work capacity judgements?
What have you found to be the least helpful aspects of occupational therapy contribution to work capacity judgements?
What assistance, if any, have you made available to occupational therapists in the provision of work capacity services?
With hindsight, what education, training or assistance would you recommend be available for occupational therapists giving work capacity testimony?

Are you aware of other medical practitioners/lawyers associated with occupational therapy work capacity testimony for the Courts? If so, to what extent have they had similar experiences to your own?

Any further comments?

Questions to ask when returning transcript of participant’s experience:

What, if anything, needs to be changed to represent your experiences of occupational therapists providing work capacity testimony?
Are you satisfied that your identity and the identities of your clients and workplace have been adequately protected in the transcript? What, if anything, needs to change?
Appendix G: Pro forma for Part 1 of In-depth Interviews

PRO FORMA FOR PART 1 OF IN-DEPTH INTERVIEWS

Name:
Preferred contacts for receipt of transcript [ ], invitation to focus group [ ] to hear presentations, to read papers and thesis [ ]
1.

2.

3.

Pseudonym:
Job title:
Current employment status: PT [ ], FT [ ], Gender: Male [ ], Female [ ]
Age range: 20-29 [ ], 30-39 [ ], 40-49 [ ], 50-59 [ ], 60-69 [ ], 70- [ ]

Expertise and/or experiences: requesting [ ], recommending [ ], providing [ ]
perusing [ ] occupational therapy reports, or requesting [ ] or providing [ ]
expert opinion regarding work capacity, or knowledge of the relevant medico-
legal processes [ ] or work legislation [ ].

Comments:


Period of involvement in area/s of expertise - past and current involvement.
Comments:

Method of Recruitment:
Appendix H: List of Open Codes
Appendix I: List of Participants’ Pseudonyms according to their Professions

**Occupational Therapists:**

OT1  Ona  
OT2  Donald  
OT3  Barbara  
OT4  Stan  
OT5  Madonna  
OT6  Sophie  
OT7  Jennifer  
OT8  James  
OT9  Bill  
OT10 Rod  
OT11 Lucy  
OT12 Sue  
OT13 Jan  
OT14 Jessie  
OT15 John  
OT16 Antionette  
OT17 Alex  
OT18 Maree  
OT19 Shaunagh

**Lawyers**

L1  Max  
L2  Scully  
L3  Martin  
L4  Sean  
L5  Jill  
L6  Paogong

**Medical Specialists**

M1  Matthew  
M2  Owen  
M3  Peter  
M4  David  
M5  Edmond  
M6  Iamra
Appendices J1-J5: Participant Verification Package including Key Findings
Dear Participant,

My PhD research into the **Contribution of Occupational Therapists to Medico-legal Decisions about Work Capacity** is nearly complete. I would like to thank you once again for the valuable assistance you gave me at the individual interview, conducted in 2001 or 2002. I completed 31 in-depth interviews with occupational therapists, medical specialists and lawyers. This provided me with nearly 1,000 pages of data to analyse. During 2003 I analysed, wrote up and reduced the data into integrated findings. I am currently in the process of developing a grounded theory from the data. This means using four stages of analysis to identify a succinct, abstract understanding of your combined experiences and perceptions of the research topic. I expect to be finished that process shortly.

The reason for the contact with you now is to let you know that your ongoing participation is assisting me to develop a grounded theory of expertise. Additionally, I wanted to inform you of my plans to substitute the focus group with individual participant feedback. I have decided to post or email the draft grounded theory to you. This will mean I can gain vital feedback from all my participants, many of whom do not live in Brisbane. It will also ensure that you remain anonymous. In the next 2 months I will send the grounded theory of 10 pages or less to you, and I will ask that you read it critically, answer 3 questions to ensure your views are reflected in the theory, make any further comments, and to return your responses to me within the following 3 weeks by email or in a stamped self-addressed envelope.

Please let me know if you prefer me to send the grounded theory and questions to an alternative email or postal address. If you have any questions at this stage please don’t hesitate to contact me on 07 – 3349 9682 or at shelley.allen@mailbox.uq.edu.au

Yours sincerely

*Shelley Allen*

17th February, 2004
Dear Participant,

In my letter to you on 14th February 2004, I indicated that my PhD research into the Contribution of Occupational Therapists to Medico-legal Decisions about Work Capacity was nearly complete. However, the analysis of the data took longer than anticipated.

In that letter I also thanked you for the valuable assistance you had given me at the individual interview, conducted in 2001 or 2002. With your assistance I was able to complete 31 in-depth interviews with occupational therapists, medical specialists and lawyers. The interviews provided me with nearly 1,000 pages of data that I analysed during 2003 and 2004. I have reduced those pages to 8 pages of Key Findings, and for your interest, I have enclosed a one-page diagrammatic overview of the research findings.

As indicated in my initial contact with you and in my letter of 14th February, I now need your further assistance to verify the Key Findings and conclude the research. Participant verification of the findings is an essential stage of my Grounded Theory research design. I estimate that this process will require up to 30 minutes of your time. I ask that you read the Key Findings, answer the 3 accompanying questions to ensure your views are reflected in the Key Findings, make any further comments, and return the Key Findings with your responses to me within the following 3 weeks (i.e., by 28th January, 2005) in the stamped self-addressed envelope provided. Please let me know if you prefer me to send the questions to an email address for your ease of reply.

I would be grateful if you treated the Key Finding confidentially. If you have any questions please do not hesitate to contact me on 07 – 3365 3004 or at shelley.allen@uq.edu.au

Once again, thank you for your valued opinions and for supporting this research.

Yours sincerely

ENCL:  8-page Key findings
1 page overview
Questions for participants
Stamped self-addressed envelope
Appendix J3: Questions for Participants about the Key Findings

Please read the Key Findings about Occupational Therapy Medico-legal Expertise in Work Capacity and answer the following questions. I am interested to know if you think this is a reasonable description of occupational therapy expertise in work capacity in the medico-legal system. Keep in mind that the findings are written to include the full range of 31 participants’ experiences and perceptions and it is not important that every aspect fits perfectly with your own experiences and perceptions (Strauss & Corbin, 1998).

**Note:** There is space in the right hand margin next to each Key Finding for your responses to questions 1 and 2.

1. Please tick clearly (✓) each Key Finding if it reflects your experiences and perceptions.

2. Please place a cross (✗) beside each Key Finding that needs modification to also reflect your experiences and perceptions. Please give examples of these suggested modifications.

3. In your view, is there anything that could be added or changed to make the Key Findings a more complete and accurate description of occupational therapy expertise that contributes to medico-legal decision about work capacity?

4. Add any other comments you wish to make.

*Thank-you for your valuable time and assistance.*
*Phone me on 07- 3365 3004 if you want to discuss any aspect.*
Appendix J4
Appendix J5: Four Clusters of Key Findings

Key Findings Cluster 1: Understanding the Medico-legal System and Occupational Therapists’ Interactions with Stakeholders

The following set of key findings was derived from the experiences and perspectives of the three participant groups. The key concept that emerged during the analysis of the interviews was “expertise.” The key findings summarise aspects of the medico-legal system relevant to occupational therapy expert opinions on work capacity, the roles of key stakeholders and their interactions with occupational therapists in the medico-legal system.

1i Participant groups identified a number of areas of common and statutory law under which work-related personal injury claims for compensation are considered. Personal injury claims may arise from work-related statutes and jurisdictions associated with workers’ compensation, compulsory third-party motor vehicle insurance, medical negligence, public and product liability, and appeals under administrative law. The medico-legal system applies common law principles to adversarial legal proceedings between opposing plaintiff/claimant and defendant parties. During these proceedings, lawyers for the plaintiff attempt to maximise the compensation for past and future economic losses while lawyers for the defendant attempt to minimise the losses, that is, damages. Participant lawyers acting for each party expressed the view that their stance is in the long-term interests of plaintiffs. There is a broad understanding of work-related medico-legal proceedings that encompass employment discrimination, rehabilitation specifically to reduce employer liability, and proceedings that conclude at compulsory mediation or conferences. Fewer than 5% of personal injury cases proceed to trial.

1ii An increasing number of cases in Australian federal and state jurisdictions utilise occupational therapy expert opinions. Occupational therapy work-related opinions may be heard in Supreme and District Courts and some tribunals and commissions.

1iii Occupational therapists’ role as experts on work capacity was initially based on their role as treating (i.e., rehabilitation) therapists and on their assessments of function in several areas of daily living. A more specific focus on work capacity has evolved over the last three decades. An increasing number of occupational therapists in Australia and other Western countries provide medico-legal services as consultants in private practice.

1iv It is the occupational therapists’ responsibility, and that of other expert witnesses to assist the courts to make fair and just decisions. Occupational therapy opinions on claimants’ residual work capacities should assist courts in determining the quantum of past and future economic loss. In the medico-legal system occupational therapy experts are expected to know their areas of expertise and any limitations to them. They must be expert at presenting their opinions in reports and in court.

1v The expert’s opinions should be unbiased, and contain reasonable recommendations. Occupational therapy experts on work capacity need to guard against their opinions being influenced by interactions with the various stakeholders including the referring solicitor, insurer and claimant.
Desirable characteristics of occupational therapy experts are: (a) being motivated to undertake the expert witness role, (b) having personal characteristics suited to the speciality, (i.e., accuracy and attention to detail, maturity, calmness and confidence when communicating, and strategic, analytical and dispassionate thinking), and (c) being able to identify and use strategies to alleviate stress and anxiety associated with experts in the medico-legal system (e.g., being adequately prepared for court).

Solicitors are mainly responsible for communication with all stakeholders including claimants, and for the financial aspects of cases. They initiate the majority of referrals to occupational therapists and provide briefings prior to experts attending court. There are some differences in understanding about whether solicitors or occupational therapy expert witnesses should initiate briefings. Occupational therapists’ interactions with solicitors may also include marketing their services to solicitors. The therapist’s medico-legal reports are a principal marketing method. Occupational therapists have developed strategies to ensure payment for their expert medico-legal services within a reasonable timeframe.

Barristers including QCs/SCs have two identified roles impacting on occupational therapists. Firstly, they advise on their involvement in medico-legal proceedings, and secondly, they conduct informal cases (e.g., mediation) and formal cases in court (e.g., trials) where they examine and cross-examine expert witnesses. The participants’ metaphors for the adversarial medico-legal system are sporting competitions and battles. These metaphors can be partly attributed to expert witnesses’ perceptions of cross-examining barristers as combative. Paradoxically, barristers have also assisted in the court valuing occupational therapy opinions, and in the development of the medico-legal specialty within occupational therapy.

Judges weigh competing evidence in cases that goes to trial, hypothesise about the future, and provide the rationale for their decisions. Judges are ultimately the stakeholders who must be persuaded by occupational therapy expert opinions on the impact of an injury.

Insurers are perceived as motivated to counteract demands for unacceptably high compensation claims by the claimants and their representatives. In turn, they may be perceived as ignoring the full impact of injuries on plaintiffs’ lives such as those reported by occupational therapists and other experts.

Occupational therapists’ expert opinions on functional capacity and employability complement the highly regarded and more frequently requested medical specialists’ opinion on diagnosis, level of impairment, prognosis and risk of re-injury.

The largest group of claimants for whom occupational therapists provide an opinion are those with musculoskeletal injuries associated with chronic pain. Claimants with cognitive impairment as a result of traumatic brain injury (TBI) form the second largest group. Claimants are most frequently referred for an opinion 2 years post injury.

Participants identified a continuum of claimant responses in the medico-legal system. At one end of the continuum is a group of claimants who are perceived to have had their lives disrupted, are in genuine pain and give an account of their work capacity consistent with the assessed medical condition. Participants perceived that a second
group has responses that have become unconsciously distorted in the medico-legal system. Claimants in the second group include those whose responses are ambiguous or understated, and who believe that their capacities are reduced to a greater extent than can be objectively measured. On rare occasions claimants may malinger, that is, their responses are consciously intended to deceive assessors. This group of clients forms a third group at the other end of the continuum. Consequently, experts need to question the motives and veracity of the claimants’ self-reports and performance when forming an opinion in the medico-legal system.
Key Findings Cluster 2: Identifying the Areas of Occupational Therapy Expertise in Work Capacity that Assist the Courts

The following set of key findings was derived from participants’ experiences and perceptions of how expert occupational therapists provide valued, credible and unbiased, expert opinion on work capacity within their areas of expertise.

2i Occupational therapy opinions are of particular value when the legal and medical professions are unable to fully answer questions about work capacity in complex, ambiguous or disputed cases. The distinctive occupational therapy areas of expertise that assist the courts are the assessment of claimants’ functional work capacities, analysis and description of jobs, and relating this information to past, present and potential jobs suitable for claimants.

2ii Specialist occupational therapy expertise in cognitive disability, hand injury, spinal cord injury and driving capacity is being increasingly recognised, especially by occupational therapists. However, there are substantial overlapping areas in specialist and generalist occupational therapy medico-legal expertise. For example, occupational therapists in both groups may assess claimants with chronic low back pain and TBI.

2iii Occupational therapy areas of expertise in work capacity relate to two concepts, function and employability. Function means the ability to perform work tasks or activities despite impairment, whereas employability means the ability to obtain employment in the open labour market despite impairment. Some participants make a further distinction between present and future employability. Lawyers and some occupational therapists emphasise that occupational therapists’ areas of expertise include future employability, while some medical specialists and some occupational therapists emphasise that their area of expertise relates to current functional work capacity for past and present jobs for which the claimant is educated, trained or experienced.

2iv Various positive influences increase the credibility of occupational therapists’ work capacity opinions. Those identified by occupational therapists include their previous work experience, relevant competencies, medico-legal experience, and performance as an expert witness in the courtroom. Occupational therapists related their credibility in the courtroom to responding effectively to cross-examination techniques used by barristers (e.g., stating that an occupational therapist is outside her/his area of professional expertise, or that the occupational therapist has adopted the medical opinion).

2v There are inherent pressures to form biased opinions in the medico-legal system. Participants identified a number of strategies for avoiding perceptions of bias (e.g., writing an opinion as if there is an opposing one, and accepting referrals from plaintiff and defendant solicitors).

2vi There is a legal tendency to recognise discrete areas of expertise. In contrast, occupational therapists recognised some areas of expertise that overlapped with other rehabilitation and vocational experts.
Key Findings Cluster 3: Occupational Therapy Methods of Assessing, Forming Opinions and Reporting on Work Capacity in Personal Injury Cases

This set of key findings was derived from the participants’ perceptions and experiences of the assessment and report writing methods used by occupational therapists who provide expert opinions on work capacity. In addition, occupational therapists provided insight into how they form opinions on the work capacity of claimants. Members of the legal profession and medical specialists made few statements about the occupational therapy assessment process, with which they have little direct experience. More commonly, they made statements about occupational therapists’ reports, based on their more direct experience. Both consistent and divergent views were noted.

3i In the medico-legal system occupational therapists use a range of work-related assessments that includes Functional Capacity Evaluations (FCEs). The range of assessments encompasses standardised marketed assessments, non-standardised individualised assessments, psychosocial assessments, cognitive assessments, job analysis, and pre-work (i.e., pre-employment and pre-placement) assessment. Occupational therapy medico-legal expertise includes understanding the strengths and weaknesses of available assessments, and understanding what the information obtained from each assessment means in relation to medico-legal decisions about economic loss.

3ii An eclectic assessment approach is the most frequently used occupational therapy approach in the medico-legal system. The eclectic assessment approach is informed by both qualitative and quantitative scientific measurement principles. It consists of combining information from various assessment methods and sources in order to compare and validate findings. Information may be obtained from observation of work-related performance, interview, objective measurement, subjective information from the claimant, and from workplaces, in-rooms and other sites.

3iii All participant groups understand that a principal advantage of occupational therapists’ assessments is their observation of work-related performance for extended periods. Strategic observation of work-related performance is critical in cases of suspected malingering or exaggeration. However, the reasons for occupational therapists’ selection of other assessment methods are less well understood by lawyers and medical specialists.

3iv Occupational therapists prefer non-standardised individualised Functional Capacity Evaluations to standardised FCEs in the medico-legal system, principally because of the perceived validity of findings. The majority of occupational therapists are reluctant to use standardised marketed FCEs alone, as they lack the required validity and reliability for the medico-legal system. In particular, they lack predictive validity for workforce participation. Standardised FCEs measure work task performance rather than employability in the workforce that is required by the medico-legal system. A further limitation of standardised marketed FCEs conducted in-rooms is that performance may differ from performance in an actual workplace environment, and for this reason, they need to be supplemented with information about workplaces from other sources.
Many non-standardised individualised assessments are based on the list of physical demands in the Dictionary of Occupational Titles (DOT) (1991). The DOT matrix enables recommendations to be made regarding suitable jobs in one of the five DOT work demand categories from sedentary to very heavy, and for levels of work skills corresponding to the functional physical capacity and qualifications of the claimant. However, some participants perceived that assessments based on the DOT have some potential limitations as the DOT lacks an assessment protocol. Furthermore, job match programs that are based on the DOT and designed for the U.S. labour market may not be applicable to Australia. Therefore, occupational therapists who use non-standardised individualised assessments develop their own assessment protocols and adapt them to the individual claimant’s situation to answer the referral questions. In addition, computer programs based on DOT provide job matches that are potentially invalid unless the occupational therapist accounts for the person’s residual functional physical capacity.

Portable standardised measures of grip strength, psychosocial factors (e.g., pain, self-efficacy, fear of re-injury) and spinal function may be used to supplement assessments of physically demanding work tasks. Although these portable measures are not a substitute for observation of claimants’ performing physically demanding work tasks, several have acceptable established levels of validity and reliability based on the self-report of the person with an injury.

There are divergent views concerning the need for occupational therapists to use standardised marketed FCEs. One view favours the use of standardised marketed FCEs because of their perceived credibility among some medico-legal stakeholders and the name signified the assessment protocol undertaken. A second view is that, based on consensus, a consistent occupational therapy FCE protocol should be adopted. A third view is the need for further research on FCEs.

Occupational therapists identified a number of psychosocial factors that impact on work capacity and that they considered were professionally appropriate for them to report. These included claimants’ pain experiences, a number of work-related attitudes and self-management skills, mood or emotional status and certain personal and family issues impacting on performance of work tasks and participation in the workforce. The impact of pain on function (work tasks) is most commonly incorporated into opinions. While occupational therapists typically incorporate measures of psychosocial functioning into rehabilitation assessments, they are cautious in giving an opinion on psychosocial functioning in the medico-legal system. A reason for caution was the difficulty supporting statements and judgements made during assessment, especially in court. In addition, other experts are perceived by lawyers and medical specialists as being more appropriate to comment, especially on causation, motivation and prognosis of psychosocial conditions. One variation on the previous finding is that several lawyers and medical specialists prefer occupational therapists to incorporate personal information about the claimant to complement objective impairment information provided by medical specialists (e.g., number of dependants, claimant’s reports of pain and impact of injury on work). As there is some overlap between personal information and psychosocial information some clarification of terms may be required.

Occupational therapists identified cognitive functioning as an additional specific area of assessment for people with TBI. This is consistent with TBI being the second largest claimant group.
Despite the advantages of obtaining authentic assessment information from job analyses and FCEs at a workplace, there may be a number of industrial and practical barriers to conducting “in vivo” assessments in the medico-legal system. Alternatives include obtaining photos with a description of the workplace, and a treating rehabilitation occupational therapist’s workplace visit report.

Pre-work assessments are conducted to limit employers’ liability. Occupational therapists provide job analyses to ensure the validity of these assessments and to assist employers to respond to anti-discrimination legislation.

The major issues for occupational therapists preparing medico-legal reports on work capacity are giving close attention and time to the reports to ensure their integrity and defensibility, and interpreting the information in order to form their opinions.

Occupational therapists analyse and synthesise assessment information to form opinions about claimants’ potential for employment and make recommendations to increase their workforce participation. Information from different sources is constantly compared with previous experiences of people working with and without injury. Identifying consistencies and accounting for inconsistencies between the various sources and types of assessment information are important foundations of occupational therapists’ opinions. Some challenges for occupational therapists when forming opinions relate to the medico-legal system, use of assessments, and professional reasoning and decision-making. One challenge is choosing a fresh range of job options for each claimant.

There are four categories of occupational therapy recommendations to increase work participation (i.e., employability). These are: (a) suitable jobs that match the person’s work capacity, (b) adaptive equipment to assist the person to return to work, (c) modified techniques to improve the person’s work capacity, and (d) educational, training or professional services.

Some participants perceived that occupational therapy reports sometimes lack objectivity and rely on self-reported information. Overall, lawyers and medical specialists agreed about high quality occupational therapy medico-legal reports. Lawyers require occupational therapists’ opinions to include objective assessment of physical capacities, a reasonable and detailed rehabilitation plan and realistic options for employment. They want reports that are brief, uncomplicated, free of bias and typographical errors. Similarly, medical specialists consider better quality reports rely on objective testing more than self-report, have transparent assessment and professional reasoning, are shorter, are personalised for each claimant, and provide an opinion of the person’s work capacity including their employability.

Advantages of occupational therapists’ reports over those of other experts are that they provide practical information about the impact of an injury on a person’s work capacity that is free of jargon and based on extended periods of observation and demonstration of work-related activities.
Key Findings Cluster 4: Systematically Improving Occupational Therapy Expert Opinions on Work Capacity

These key findings were derived from the participants’ perspectives and experiences relating to the trends in the medico-legal system, their recommendations for broad professional development strategies, and specific strategies to develop expert opinions on work capacity through reporting and assessment practices. Hence, the training of occupational therapy expert witnesses on work capacity should incorporate the following findings.

4i The general trends increasing demand for occupational therapy medico-legal opinions on work capacity are the legal professions’ increased respect for and reliance on occupational therapy work-related expert opinions to assist with the faster processing of claims in an increasing range of jurisdictions, and increased levels of work-related litigation.

4ii However, trends increasing demand may be moderated to some extent by trends to decrease access to common law and cap compensation settlements. These trends may create economic disincentives that decrease demand for occupational therapy work capacity opinions. In the medico-legal system, the medical and legal professions are predicted to continue to have the primary influences on the assessment of workers with injury. Some trends indicate increased medicalisation of the medico-legal system through the widespread use and acceptance of impairment ratings. This trend is likely to be off-set with the awareness, expressed by several participants, for the need for assessments of work disability to be individualised and to assess the impact of injury on work activities and work participation as well as impairment.

4iii A specific trend emerging as a consequence of the previous trends is that the courts may seek fewer expert witnesses with greater expertise and who are more accountable and responsive to the needs of the courts. That is, they can provide unbiased opinions supported with verifiable sources about topics on which the courts lack expertise. Increased use of court-appointed experts, panels of experts and mutually-agreed experts are predicted.

4iv The increasing trends to compulsory pre-trial mediation and negotiation are predicted to increase the current trend towards the expert’s report being the primary source of expert opinion.

4v Occupational therapy participants indicate that the level of expertise for the provision of a medico-legal opinion is not simply a matter of the years of experience that an occupational therapist has gained, but also depends on the type of experience the occupational therapists has, and the type of opinion requested by the court. (The minimum number of preferred years of experience for an occupational therapy expert ranged from 1 year to answer a question about a client’s treatment program up to 5 years before commencing training in FCEs for medico-legal purposes). Experiences in occupational and vocational rehabilitation are especially useful as they generate knowledge of workplaces and jobs, and provide the basis of realistic recommendations about work participation for people with injury.
4vi  Professional associations, workplaces, universities and individuals have responsibilities for professional development activities to improve expert opinion. Recommended roles for the professional association are to maintain an ethical culture and ethical practices, train and advise practitioners on using appropriate assessments, reporting formats and developing opinions. A proposed new role for Occupational Therapy Australia is the accreditation of specialists (e.g., in traumatic brain injury and spinal cord injury) to meet the needs of the medico-legal system. A range of supportive practices including peer review, mentoring, discussion of complex cases, quality assurance programs and supportive colleagues can be provided at the workplace. Paid supervision and programs to develop staff competencies in medico-legal work capacity assessment and reporting can also be provided at the workplace. Universities are well placed to provide post-graduate education for the medico-legal speciality following some preliminary undergraduate education, while professional organisations may provide continuing education. A comprehensive post-graduate education module for occupational therapists would have components on: (a) work, litigation and occupational therapy, (b) pre-assessment preparation, (c) assessment and report writing, and (d) court proceedings. Individual therapists can independently prepare for the expert witness role and simultaneously develop confidence and competence using such strategies as self-appraisal, study and observing other expert witnesses in court. A range of professional associations, electronic databases, websites and publications offer medico-legal resources.

4vii  The three participant groups identified key principles to enhance occupational therapy expert opinion. They include: (a) state an opinion authoritatively and confidently as an expert in a specialised area; (b) stay within your areas of expertise and, as required, refer to another expert; (c) give an unbiased, thorough and truthful opinion to gain respect at trial; (d) distinguish between what is reported and observed and discuss any discrepancies; (e) recommend suitable redeployment, especially for people with degenerative conditions; (f) speculate realistically about suitable jobs for claimants; (g) include recommendations for rehabilitation, equipment, workplace modifications, training and retraining; (h) adopt a consistent occupational therapy assessment and reporting template; (i) shorten reports to approximately three pages by reducing detail, and (j) use research evidence selectively to support opinions.

4viii  An emerging issue identified in this research is the potential incongruity between occupational therapy and medical specialists’ understanding of research evidence and the court’s understanding of legal evidence from experts. Occupational therapists would benefit from clarification of the similarities and differences between research and legal evidence. They would also benefit from the availability of further research evidence to support some occupational therapy opinions.
Appendix K: Sample FCE Format based on the Dictionary of Occupational Titles (1991b)

PHYSICAL JOB DEMANDS/FUNCTIONAL CAPACITY ANALYSIS

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**JOB DEMANDS**

0. Not Required
1. Rarely Required (1-5%)  
   (1-5%)
2. Occasionally Required (5-33%)  
   Minor job demands
3. Frequently Required (33-65%)  
   Significant job demand
4. Constantly Required (65-100%)  
   Major job demand

**FUNCTIONAL CAPACITY**

0. Unable to manage &/  
   Severely limited
1. Partial ability &/  
   Able to do rarely
2. Partial ability &/  
   Able to do occasionally
3. Mildly limited &/  
   Able to do frequently
4. Unlimited &/  
   Maximal ability
Sample FCE Format based on the

Dictionary of Occupational Titles (1991b) (continued)

The following table is provided as an aid in the determination of Strength Levels:

<table>
<thead>
<tr>
<th>RATING</th>
<th>Occasionally (O)</th>
<th>Frequently (F)</th>
<th>Constantly (C)</th>
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<tr>
<td>SEDENTARY</td>
<td>* - 10</td>
<td>*</td>
<td>*</td>
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<tr>
<td>LIGHT</td>
<td>* - 20</td>
<td>* - 10</td>
<td>*</td>
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<tr>
<td>MEDIUM</td>
<td>20 - 50</td>
<td>10 - 25</td>
<td>* - 10</td>
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<td>HEAVY</td>
<td>50 - 100</td>
<td>25 - 50</td>
<td>10 - 20</td>
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<td>VERY HEAVY</td>
<td>100 +</td>
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* negligible weight

The range excludes the lower number and includes the higher number, i.e., the range 10 - 25 excludes 10 (begins at 10 +) and includes 25. Overlapping ranges of * - 10 in the Occasionally (O) column for Sedentary and Light jobs are differentiated on the basis of the worker's posture and whether work is performed at a production rate. For example, all Sedentary jobs involve constantly sitting. However, in some jobs workers sit constantly but exert force of an amount or at a frequency rate that exceeds the limits for Sedentary. Such jobs are, therefore, rated at least Light.

<table>
<thead>
<tr>
<th>Code</th>
<th>Frequency</th>
<th>Definition</th>
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<tr>
<td>N</td>
<td>Not Present</td>
<td>Activity or condition does not exist.</td>
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<tr>
<td>O</td>
<td>Occasionally</td>
<td>Activity or condition exists up to 1/3 of the time.</td>
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<tr>
<td>F</td>
<td>Frequently</td>
<td>Activity or condition exists from 1/3 to 2/3 of the time.</td>
</tr>
<tr>
<td>C</td>
<td>Constantly</td>
<td>Activity or condition exists 2/3 or more of the time.</td>
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Note. The weights in the table are expressed in pounds. The equivalent weights in kilograms are as follows:

- 10lbs. = 4.6kgs.
- 20lbs. = 9.2kgs.
- 50lbs. = 23kgs.
- 100lbs = 46kgs.