Psychiatric Residents’ Experience Conducting Disability Evaluations

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Objective: The increasing frequency and societal cost of psychiatric disability underscore the need for accuracy in evaluating patients who seek disability benefits. The authors investigated senior psychiatric residents’ experiences performing disability evaluations, their self-assessment of competence for this task, and whether they perceived a need for more training.

Methods: Seventy-nine third- and fourth-year psychiatric residents in Massachusetts and Rhode Island training programs were surveyed from May to June in 2008. Participants were asked about the frequency of requests and completion of disability evaluations, the practice patterns followed when performing evaluations, the identification of role and potential conflict of interest in doing evaluations, and their sense of preparedness and need for more training.

Results: Residents reported having limited experience performing disability evaluations and followed a variety of practice patterns when performing evaluations. They reported having a limited understanding of what constitutes psychiatric disability and a lack of confidence in their ability to perform evaluations accurately. A significant minority had identified patients as disabled despite believing otherwise. A majority of residents reported receiving no didactics on psychiatric disability and desired more training.

Conclusion: Residents may be unprepared to perform disability evaluations. Residency programs may need to provide additional training.

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n the United States, mental disorders (excluding mental retardation) rank highest among medical diagnoses as a reason for federal disability benefits, comprising 30% of all Social Security claims awarded (1). From 2000 to 2007, the number of Social Security beneficiaries disabled by a mental disorder rose from 1.4 million to 3.2 million (1, 2). The annual cost in lost work productivity from psychiatric disabilities is estimated to be $150 billion (3), with $44 to $51.5 billion attributed to depressive disorders alone (4, 5). The presence of moderate or severe major depression is the single greatest predictor of failure to return to work from short-term disability (3).

Assessments for work-related disability are among the most common nonclinical tasks requested of outpatient psychiatrists (6, 7). Notwithstanding the available resources and guidelines on how to conduct disability evaluations (8–10), scant research exists on the practice patterns of psychiatrists who perform them. Preliminary data suggest high variability in disability determinations between psychiatrists who examine the same evidence (11). Furthermore, nonforensic psychiatrists may have less appreciation than forensic psychiatrists for the potential conflict between serving as both clinician and objective evaluator (12, 13). Some psychiatrists refuse to perform disability assessments altogether (12).

Despite these challenges, treating psychiatrists may be best positioned to evaluate their patients’ mental impairments. State and federal agencies that oversee determinations of disability, such as the Social Security Administration, value input from treating physicians over independent examiners “because they are likely to be the medical professionals most able to provide a detailed longitudinal picture of the claimant’s impairments and may bring a unique perspective to the medical evidence that cannot be obtained from the medical findings alone or from reports of individual examinations or brief hospitalizations” (14).
Determining work-related disability receives relatively little attention, however, in residency training (15). In this study we examined how much exposure and didactics senior residents have on performing disability evaluations and how they perceive various related issues. We hypothesized that residents would report feeling unprepared to balance their roles as clinician and objective evaluator and that many would report having identified patients as disabled despite believing otherwise. We also hypothesized that residents would identify a need for more training on performing disability evaluations and that third-year residents would identify a greater need than their fourth-year colleagues. We were also interested in whether having didactics would be associated with feeling better prepared and less pressured to portray patients as more disabled than residents thought. To our knowledge, no prior study has examined any of these issues.

Methods

A survey questionnaire to assess residents’ experiences conducting disability evaluations was developed, pilot tested for clarity and content with a group of residents and psychiatrists, and revised based on their feedback. The survey (available upon request) included 20 items with scaled (Likert-type) or counted responses, three demographic questions, and a comments section. Survey content domains included the frequency with which disability evaluations were requested and completed, the amount of didactics and supervision on psychiatric disability, practice patterns for conducting evaluations, attitudes toward conducting evaluations, potential for over-identification of disability, confidence and sense of preparedness in performing evaluations, and perceived need for additional training.

The survey was offered to all third- and fourth-year residents in eight adult psychiatry programs accredited by the Accreditation Council for Graduate Medical Education in Massachusetts and Rhode Island in May-June 2008. Only residents at the end of their third or fourth year of training were surveyed so that responses would reflect perspectives of residents just about to complete their third-year outpatient rotation or residency training. Six training programs permitted a site visit for survey administration; surveys were mailed or e-mailed to residents at the other two programs and to residents not present during site visits. Because residents from one program were not permitted to conduct disability evaluations, we excluded their answers pertaining to actual experience performing evaluations. However, because they might be expected to perform disability evaluations during their career, we included their answers regarding didactics on psychiatric disability, confidence and sense of preparedness in performing evaluations, and perceived need for additional training. Study participation was voluntary and confidential, and participants provided written informed consent. The Butler Hospital institutional review board approved this study.

Descriptive statistics examined responses to survey items. We used t tests and chi-square analyses for selected group comparisons. An alpha level of 0.05 was used to determine statistical significance.

Results

Seventy-nine of 138 eligible respondents completed the survey for a response rate of 57.2%. Individual program response rates ranged from 8.3% to 100%. The respondents’ mean age was 32.8 years old (SD=3.7); 57% were men (n=45).

Among eligible respondents, only 2.9% (n=2) reported having completed no disability evaluations thus far during residency. Eighty percent (n=56) had completed 1–10 evaluations; 11.4% (n=8) had completed 11–20; and 5.7% (n=4) had completed 21–30. Seventy percent of respondents (n=49) reported being asked to complete an average of less than one disability evaluation each month; 28.6% (n=20), an average of 1–2 evaluations monthly; and 1.4% (n=1), an average of 3–4 evaluations monthly.

Regarding practice patterns (Figure 1), residents reported frequently agreeing to perform evaluations when asked (mean=4.83, SD=1.69, scaled from 1="never" to 3="sometimes" to 5="frequently" to 7="always"). Mean responses for the following items were between “sometimes” and “frequently”: completing disability forms with the patient present (mean=4.01, SD=1.97), discussing limitations on confidentiality involved in this task (mean=4.59, SD=2.12), and feeling pressured to portray patients as more disabled than the residents thought they actually were (mean=4.14, SD=1.57). Residents sought guidance from supervisors (mean=4.25, SD=2.0) and reported that supervisors gave conflicting opinions on what constitutes disability (mean=4.19, SD=1.69) “sometimes” to “frequently.”

Figure 2 shows residents’ perceptions of the extent to which they serve as an advocate for patients when completing disability evaluations (mean=4.79, SD=1.4) and