

# **THE CANADIAN SOCIETY OF MEDICAL EVALUATORS**

## **VIDEO SURVEILLANCE**

### **PREAMBLE**

Independent Medical Evaluations are requested by third parties seeking answers to a wide variety of clinical and medico-legal questions pertaining to quality of the assessment, rehabilitation needs and efforts, entitlement to benefits, impairment rating, disability etc. The Evaluator must carefully consider and give appropriate weight to all information provided, applying critical appraisal in order to create a comprehensive, objective, evidence-based opinion.

Although the primary sources of information are typically clinical – direct evaluation and medical documentation review – other sources of information can be given consideration when appropriate, even when there may be stigmatization by the subject as to perceived intrusiveness.

It is not uncommon in the course of caregiving to seek secondary sources of information. Some are objective such as laboratory tests. Some mix objective and subjective (professional) elements such as the observations of paramedical personnel on wards, in therapy clinic or during FCE. Some are subjective (layperson) such as the observations of relatives, friends, co-workers etc.

Surveillance videotapes provide yet another form of observational secondary information source. The records may be consensual as to time and place, as in the case of Sleep Lab or FCE records. Consensual or not, the usefulness of the videotape turns on the lack of ability of the subject to influence the information being recorded.

Consideration of the contents of videotape does not violate the paradigm of the medical evaluation process, common to caregiving and the IME. The clinician sets out to generate and weave together the clinical history and examination into a construct from which hypotheses are made and a differential diagnostic list is formulated. Assumptions are further tested by reference to medical records and other secondary information sources such as x-ray, and lab. The process of evolution of the evidence-based Most Likely Diagnosis is enhanced, rather than violated, by seeking observational input: I.E. on the ward one uses input from nurses and therapists.

In the setting of third-party evaluation, as in the caregiving setting, effective evaluation depends upon the comprehensiveness, representativeness and accuracy of information provided. The extent to which a patient can and will provide useful information about symptoms varies greatly, merely on the basis of limitations of memory, observer bias, level of concern etc. Variations in emphasis may be related to language, personality, culture, knowledge and/or beliefs. Reference to temporal links or other landmarks may be highly subjective and wildly inaccurate.

Reporting on functional ability and activity involve considerably greater levels of complexity for the patient, so much so that in some clinical settings only detailed questionnaires and diaries are found to be usable. Even then, the reliability of the source and the validity of the information must undergo critical appraisal.

Surveillance videotape may offer the evaluator a further source of information about functional ability and activity. As indicated above, advantages may include the inability of the claimant to control relevant parameters of time, place, or activity content. Although having the stigma of being perceived as intrusive to privacy, the creation of such an information sources is by it's very nature most useful when the subject and those around him/her unaware and able to act naturally within normal environments.

As with any secondary source of information, the value to the analytic process depends greatly on the extent to which there is an existing, detailed database from which specific answers to well-founded questions can be sought, and assumptions tested. Direct review of videotape by the evaluator may afford the ability to answer specific questions and test assumptions concerning such matters as the extent to which there is apprehension, avoidance, effort at accommodation as well as successful development of adaptive skill, reliance upon and mastery of adaptive aids and devices. One may determine whether the subject is consistently safe in different, public situations.

The evaluator may be confronted by extreme and potentially misrepresentative claims at either end of the activity spectrum, requiring testing of claimant reliability and claim validity. This may include claims of "I can't and I don't" in pursuit of disability certification and pension benefits concerning continuous inability and avoidance of specific recreational or work tasks. At the other end of the spectrum it may included "I can and do" claims in pursuit of legal sanction such, as physical capacity to maintain a driver or pilot's license.

Although secondary sources of information, including surveillance, can offer information about the reliability of a narrative history, and test the validity of the complaints, the evaluator must be cautious in making further inferences as to intent. Willful deception may be difficult to assess.

During the course of an IME the evaluator must continuously ask whether information is valid, the source reliable, and the conclusions plausible. The same questions must be asked regarding the videotaped information.

Similarly, it is improper for the evaluator to refuse to review or consider the evidence developed from surveillance merely on the basis of this information being somehow less acceptable that a x-ray.

As there is no doctor patient relationship in a 3<sup>rd</sup> party Independent Medical Examination; there is no fiduciary responsibility to discuss any information being evaluated for the assessment. There may be an obligation in inform the claimant that a videotape is to be reviewed, should there be a pre-existing contractual requirement to do so. However it is incumbent upon the evaluator to evaluate all material fairly without any preconceived bias.

## **STANDARDS FOR REVIEWING AND EVALUATING VIDEO SURVEILLANCE**

1. The report should explicitly state the basis upon which identification was made.
2. The setting or location of the surveillance should be one, which is conducive to natural and representative activity.
3. The surveillance should be free of contrivance.
4. The surveillance should be free of possibility that claimant is aware.
5. There should be adequate frequency and randomness so as to demonstrate a representative set of samples of natural activity.
6. The evaluation of the surveillance in the report should clearly appreciate what the claimant is doing, including the necessary capacities and actual demands of the activity. It should not make unfounded suppositions. What is obvious to the evaluator must be explainable to a layperson.
7. The evaluator should correlate the activities in the surveillance to other information such as the medical records of complaints, alleged inability's, findings and treatments made in the same period of time.
8. The evaluator should determine the relationship between the surveillance information and the existing database of symptoms, activity reports, impairment findings, and related inferences concerning ability and activity. The evaluator must also determine the accuracy of the various elements of evaluation as predictors of actual activity.
9. The evaluator should determine the impact of the surveillance on the findings and predictions of other evaluations, one's own or others.
10. The evaluator after examining the claimant and reviewing the surveillance, can and should revise stated opinion in the face of compelling evidence or argument to the contrary. This can occur in such circumstances where the surveillance, while meeting the other criteria, completely contradicts the claims of abilities or inability's.
11. The evaluator should not refuse to consider evidence developed from surveillance without first having reviewed the material. Where appropriate and if the surveillance material meets the other standards, it is to be considered as being equally relevant as all other information, both clinical and non-clinical.
12. It is improper for the evaluator to review and make use of the narrative description of surveillance without directly watching the videotape in its entirety.

13. It is improper for an evaluator to exceed his/her area of expertise and level of expertise and level of experience and confidence when attempting to interpret surveillance. The evaluator must avoid both over-interpretation and under-interpretation, since surveillance resembles other information, which can generate false-positive or false-negative conclusions.
14. It is improper for the evaluator to take a moral stand on the conclusions arising from surveillance. Only medical issues involving misrepresentation are within the domain of the evaluation.
15. The evaluator must be prepared to disclose whether the surveillance was reviewed prior to or after meeting the claimant and for what reasons.
16. The evaluator is under no obligation to directly discuss the surveillance with the claimant.
17. In reporting on the surveillance it should be reported in a manner which indicates its use as a tool for evaluating function, either confirming or refuting other functional evaluations.
18. Direct discussion (i.e. Viewing the surveillance in the presence of the claimant followed by discussion) is at the discretion of the evaluator. As there is no doctor patient relationship in a 3<sup>rd</sup> party Independent Medical Examination; there is no fiduciary responsibility to discuss any information being evaluated for the assessment. However it is incumbent upon the evaluator to still maintain the ethics and professional demeanor which is required in any medical examination and to evaluate all material fairly without any preconceived bias.
19. The claimant should be informed prior to the assessment, that all non-clinical information such as video surveillance will, if made available be reviewed. \* It is appropriate to respond to a claimant's inquiry that surveillance has been made available for review and will be commented on in the context of the entire evaluation, according to these standards and after review of all available documents, tests and the medical evaluation.

- *This information/notification is present in the CSME claimant information brochure.*