Fitness for Duty Examinations

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Background

Employers occasionally have a concern about an employee's ability to perform usual work duties. If the employee has shown psychological or emotional instability, anger in the workplace, psychosis, or drug or alcohol problems, the employer may request a psychological fitness-for-duty (FFD) examination. If the employee has experienced a seizure, stroke, traumatic brain injury, or developed other forms of neuropathology, the employer may request a neuropsychological FFD examination.

In a psychological FFD examination, the employer wants to understand the impact and risks of the psychological or emotional instability. In particular, will this instability pose any risk of harm in the workplace, either to the employee or to other coworkers? The employer also wants to know whether the disturbance has an impact on the employee's abilities to perform the essential duties of their job. The questions become especially important in safety-sensitive positions in which risk factors are multiplied by the potential loss to human life and the particular vulnerabilities of the workplace itself. The employer will also want to know if the employee can return to work, whether treatment will facilitate the return and whether there are any signs that the employee might need more support or assistance once they return to work.

In a neuropsychological FFD examination, the employer's questions center on the impact of the employee's neuropathology in the workplace. The questions about risk in a safety-sensitive position are essentially the same, but the issues typically concern the cognitive abilities of the employee and whether these can be ameliorated so that the particular job can be performed without limitations or restrictions.

Nature of the Referral

The referral for a psychological or neuropsychological FFD examination may come directly from the employer, or it may occur through a company especially dedicated to handling medicolegal referrals. The referral through an independent company may be preferable from the points of view of the employer, the employee, and the examiner. If the referral is handled correctly, the independent company can help educate the employer about the legal nuances of the FFD examination, informing the company about what to expect and how to ask the right kinds of questions. It can be more difficult if the referral is done directly from the employer to the examiner, as the examiner will have to understand the

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L. D. Ravdin, H. L. Katzen (eds.), *Handbook on the Neuropsychology of Aging and Dementia*,
Clinical Handbooks in Neuropsychology, https://doi.org/10.1007/978-3-319-93497-6_17

limitations and nuances of the referral in order to help educate the employer appropriately. Moreover, the independent company provides a buffer between the employer and the examiner. This buffer is useful from the employee's point of view, as it can be communicated that the examiner's opinion is independent of the employer's particular point of view, being derived from standardized psychological and neuropsychological methods that include standardized testing, direct and collateral interviews, and a review of relevant records.

Whether the evaluation is done directly through the employer or through an independent company, it must be made clear to the employee at the outset that there will not be the typical doctor-patient relationship and that federal privacy laws under HIPAA may be limited. It must also be clear to the employee that the information gathered in the evaluation will be shared with the employer and that the findings may have an impact on employment.

Nature of the Examination

Under Equal Employment Opportunity Commission (EEOC) rules, the medical records sought by the employer for review by the examiner must be particularly related to the psychological or neuropsychological issue that is causing the workplace problem. Moreover, neither the employer nor the examiner can ask for information that violates the Genetic Information Nondiscrimination Act (GINA). This means that neither the employer nor the examiner can ask the examinee whether relatives have had similar symptoms or problems. If genetic testing has been performed, that information cannot be sought or disclosed. Essentially, the entire examination and all the inquiries must be job-related and borne out of business necessity [1]. The reader will note that these restrictions are the opposite of what is typically necessary in a clinical referral or disability independent examination in which such information may become probative in determining the nature and extent of relevant psychological or neuropsychological problems.

Informed Consent

Whether the FFD examination is being performed through an independent company or not, this writer finds it helpful to include his own informed consent (IC) notice. The employee must initial each paragraph of the consent form and paraphrase its content so that the examiner is clear that the employee's consent is truly informed. The employee must also sign and date the IC notice.

The IC notice ethically discloses the purposes, intended uses, and possible outcomes of the FFD examination [2]. It is helpful in the beginning to disclose that the employer's company has requested this evaluation. If an intermediary (e.g., independent company) is being used by the employer for the examination arrangement, that fact is also stated. The employee is notified that the employer is paying the fee for the evaluation and that the employer is regarded as the examiner's client. The employee must also be informed that the examiner will produce a report that answers the employer's questions about the employee's fitness for duty for the employee's particular job position.

The nature of the evaluation and its purpose must be fully explained. The employee must know that the goal is to determine if the employee can perform essential job tasks. The potential benefits and risks of a FFD examination should also be explained. Potentially, the examination could help or hurt the employee's chances to return to work, and discussion of the employee's problems may also be upsetting.

Thus, the employee must be informed that the usual rules about confidentiality do not apply, as the employer will get to see the report, which answers the employer's questions. However, the employee must also be informed of the typical limits of confidentiality based on applicable state laws about abuse or harm to vulnerable persons or about a duty to warn if another person's life is specifically threatened.

Concerning the provision of information, particularly if an independent company is involved, the employee must be informed that the examiner will be exchanging information with this

intermediary company and vice versa, which may include medical records, job position duties, and the employer's concerns, not to mention the final report.

The employee must also be informed that while participation and the authorization of records exchange are voluntary and that revocation can be achieved by writing a revocation letter to the examiner or to the IME company, the act of revocation can only be achieved if the examiner and the independent company have not already relied upon the authorization to submit a report or exchange records. This writer finds it useful to use the metaphor, "You can't unring a bell." The employee should also be informed that they do not have to answer questions that are too distressing, though the examiner may ask why the employee is distressed and record the reasons in the report.

It is also important to inform the employee that no recordings of the examination are permitted, though some states require that employees be allowed to do this if they want to. This policy exists to protect the integrity of the examination, particularly about test security [3] and third-party observer issues [4].

The examiner should make it clear that the employee is not the patient of the examiner and that treatment or advice cannot be proffered. This writer finds it helpful to state within the IC notice that the examiner will offer respect for the employee's dignity and person, but if treatment or advice is needed, it must be obtained from the employee's own doctor(s).

Short and Long Reports

The typical long report is just like any psychological or neuropsychological disability IME report, providing all the background, records review, interview, collateral interviews, findings of testing, analyses, diagnoses, summary, and the answering of questions.

For a FFD examination, however, a short report is frequently done in an ethical manner that discloses that full testing, records review, interviewing, collateral interviews, and test findings were all done using standard procedures, but only the answering of questions is being tendered. The short report thus achieves the minimum necessary communication to answer the referral questions about the employee's work-related issues, whether further time off or treatment is necessary to achieve work stability; whether there is a risk to employee, coworker, or work if environment safety exists; and whether management can identify any red flags concerning future problems the employee might have.

By issuing a short report, the examiner protects the client (i.e., the employer) against disclosure that may be seen as discriminatory against the employee. Moreover and more to the point, the short report is seen as being entirely work-related, as it simply states that a psychological or neuropsychological evaluation was done and then merely answers the work-related questions about the employee.

However, even though purely work-related, no report is entirely free of incidental disclosures about the employee's condition, as the employer's work-related concerns will naturally involve the psychological or neuropsychological reasons the employer has asked the employee to take a leave from work and the reasons the employer has asked the examiner for evaluation.

When using a short report, all of the testing, background, and results are archived (by the examiner and potentially by the independent company psychologist, if they have one) against a possible future legal action that may render it necessary for this information to come to light.

Disclaimer in Report

Disclaimers are usually based upon prevailing psychological wisdom. The evaluator is certainly not going to promise perfect predictability, but it must be kept in mind that the employer is seeking psychological opinion and some confidence in the advice about the work-related issues regarding the psychological or neuropsychological problem(s) the employee has.

First, it is helpful to state the obvious to the employer: *The evaluation is based only on information available to the examiner at the time*

of the evaluation. The disclaimer should make it clear that additional information might yield different opinions or conclusions. It is helpful to state the other obvious fact that other records or resources that were not available to the examiner might actually exist. The message conveyed is clear, namely, that the evaluator is limited by the information given to them at any one time.

Of course, the entire psychological enterprise of assessment is based upon probabilities that are inherent in classification accuracy and in error terms concerning cognitive status and impairment levels. While the employer is typically not interested in the scientific background regarding the psychologist's methods, the examiner must still convey that absolute statements and conclusions cannot be rendered and that any opinion will be given within a *reasonable degree of psychological probability*.

This phrase about psychological probability is somewhat ritualistic and fairly diluted, and it is analogous to the *reasonable degree of medical certainty* often uttered by medical experts in the courtroom. The more diluted *probability* terminology is in my opinion preferable, as it more directly relates to how psychologists interact with their data. While these FFD cases rarely, if ever, go to court, the psychologist should be prepared to articulate the factors that participated in the opinions offered and the reasoning that led to the ruling out of alternative hypotheses. This preparation is especially important in the writing of a short report, which does not usually include the examiner's reasoning or other probability statements. Parenthetically, this is the reason that a short report may not take that much less time than a long report, and thus the pricing of the short report should take these factors into consideration.

It is also helpful to include a warning that it is not possible to predict dangerous behavior in individual cases with any degree of confidence. Concerning the risks of dangerous and violent behavior, the evaluator may wish to consult the *Handbook of Violence Risk Assessment* [5], with the caveat that most of the techniques and statistics discussed are about criminal offenders, which renders the predictions somewhat out of context for FFD examinations.

Nevertheless, knowledge of approaches to risk assessment is important. From the introductory chapter on risk assessment tools [6], it is helpful to note the three main approaches to risk assessment: (1) structured professional judgment, (2) actuarial, and (3) a behavioral approach, termed *anamnestic*; all rely on the gathering of prior information concerning the behavior of the individual. The structured approach focuses on known risk factors; the actuarial approach is considered a formal method that relies on predictors and the weights assigned to them; and the anamnestic approach is more of a process of gathering detailed information about the individual's history, especially the history of violence. The goal is to identify risk factors that are recurring in this individual's violence history, thereby identifying the "red flags" that are helpful for discussing this individual's history of violence.

The reader will note that these methods are likely to be far more detailed in the context of criminal violence and recidivism and are less likely to be as productive in the context of a single outburst that necessitated a FFD examination. Therefore, it is wise to advise management in the context of a disclaimer that a psychological evaluation is complementary to (but does not replace) a more detailed investigation of the employee as might be done in a private investigation. Moreover, the psychologist will not be making the ultimate managerial decision in the FFD examination, which is the sole responsibility of the employer.

Nevertheless, the disclaimer notwithstanding, the rubric that understanding the detail of previous behavior is helpful in predicting future behavior should be kept in mind. Thus, the detailed questioning that identifies the context and history of the employee's violence or emotional outburst goes a long way to explain results on psychological testing.

Validity of the Examination

In a FFD examination, the employee typically desires to return to work. The presentation for someone with this motivation usually involves an

attempt to look as good as possible to the examiner in all kinds of ways, especially emotionally and psychologically. Thus, the presentation often involves a denial of emotional and psychological pathology and frequently an attempt to appear almost virtuous and as having exceptional psychological adjustment.

This presentation is opposite that in examinations for disability, civil litigation, and criminal adjudication in which the motivation may be for "secondary gain," which includes monetary benefits or awards, or freedom from punishment. In these cases, many individuals attempt to appear worse than they are in terms of having neurocognitive, emotional, or psychological pathology. This kind of negative impression management for the purpose of receiving "secondary gain" is termed *malingering*.

Chafetz, Prentkowski, and Rao [7] published a work motivation study that compared social security disability (SSD) claimants, who were asserting an inability to work due to cognitive or psychological problems, with state vocational rehabilitation (SVR) claimants, who were ostensibly attempting to work or to be educated in order to work. The third group for comparison was child protection (CP) claimants, who were required to undergo examination during the process of attempting to get their children back from state custody.

In this study, 45.5% of the SSD claimants met established criteria for malingering, while only 6.7% of the SVR claimants did so. When the individuals in the SVR group who met criteria for malingering were further investigated, it was discovered that all of these individuals were either simultaneously seeking disability or had been sent from the disability office for concerns about residual functional capacity. Thus, it was indeed possible that these individuals had a hidden agenda concerning disability that was different from their ostensible reason for seeking help through the SVR office. Moreover, none (0.0%) of the CP claimants met criteria for malingering. In all three groups, IQ (for non-malingering individuals) was between 68 and 72, thus indicating that it was the goals of the claimants, rather than intellectual impairment, which affected validity test failure.

In a FFD examination, the psychologist typically has access to several scales that are helpful in assessing the validity of the examination when someone is attempting to look as good as possible and in doing so may be hiding pathology. For example, the Personality Assessment Inventory (PAI) [8] has a positive impression management (PIM) scale with item content that involves a very favorable impression or the denial of relatively minor faults. These items had low endorsement frequencies in the normative groups. Moderate elevations of the PIM scale indicated that the examinee attempted to present as relatively free of shortcomings that are commonplace and usually freely admitted. This presentation likely involves underreporting of pathology. When PIM scores are significantly elevated (>67 T), it is an indication the examinee attempted to present as exceptionally free of common shortcomings, indicating a significant level of underreporting that leaves interpretation of the clinical scales suspect. The examiner needs to be clear that this is not a case involving lack of pathology but merely a presentation as if the examinee has no pathology.

On the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) [9], the uncommon virtues (*L*) scale assesses whether the examinee presented in a favorable light by denying common shortcomings that are usually easily admitted. While this scale was previously termed the *lie scale*, the new name reflects a more objective behavioral description rather than an attempt to draw an inference about motives. As with the PIM scale on the PAI, the *L* scale assesses underreporting from the point of view of denial of common faults and thus ultimately denial of pathology. When *L* <65 T, there is no evidence of underreporting, and the profile is considered interpretable. The next two successive levels occur in the *L* ranges of 65 T–69 T and 70 T–79 T. In an otherwise consistent profile without significant evidence of positive (yea-saying) or negative (nay-saying) response bias, these ranges indicate successively higher levels of underreporting versus having traditional upbringing (that usually includes religious virtues). When *L* >79 T, the MMPI-2-RF findings

are probably invalid due to underreporting, though occasionally some scales may be elevated in spite of the underreporting. However, absence of clinical scale elevations is uninterpretable.

Curiously, the issue of traditional religious or faith-based upbringing as the counterpart to attempted underreporting in the modestly elevated ranges of *L* does not have much empirical support. Rosen, Baldwin, and Smith [10] performed meta-analyses of 11 published MMPI studies and 12 MMPI-2 studies with religious or faith-based samples. Only one of the MMPI religious samples had an elevated mean *L* scale score. The MMPI-2 samples had considerable heterogeneity, with overall moderate *L*-scale elevations in religious samples of only about 5 T points.

The MMPI-2-RF also employs the Adjustment Validity scale (*K*). Elevations on *K* indicate that the examinee presented as well-adjusted. With higher *K* scores, the presentation is that of more and more adjustment, with the consequent view that the examinee is underreporting. This interpretation is especially apparent in a FFD examination in which the examinee might have a drinking/drug problem, a divorce, or some other emotional upheaval. The contrast between life upheaval and exceptional psychological adjustment is often quite telling. When $K < 60$, no underreporting is evident. As *K* moves up into the 60 T–65 T and 66 T–69 T ranges, there is increasing evidence of underreporting versus the examinee having better and better psychological adjustment. In these ranges, the examiner must contrast the adjustment hypothesis with the life circumstances. However, when $K > 69$ T, the exceptional adjustment becomes more unlikely, and the interpretation is that of underreporting.

The Paulhus Deception Scale (PDS) [11] is also useful in the FFD context, as it measures two kinds of socially desirable responding: impression management (IM) and self-deception (SD). The PDS is a freestanding self-report questionnaire that takes about 5–7 min to complete, and it requires only a fifth-grade reading level. The IM scale is relatively uncorrelated with the SD scale. The scoring on the PDS assigns points only for extreme responses (1 or 5) on a 5-point scale (though sometimes 2 or 4 are extreme enough to derive a point).

Consistent with the *L* scale on the MMPI-2-RF and the PIM scale on the PAI, the IM scale of the PDS measures the degree to which examinees say they typically perform desirable, yet uncommon, behaviors (e.g., in the manual: "I always obey laws even if I'm unlikely to get caught"). If several of these kinds of items are rated in the extreme, with high claims on unlikely desirable behaviors, it appears that the examinee is attempting to impress the examiner. In "high-demand" situations such as the FFD examination, the interpretation tends more toward deliberate distortion [11].

The SD scale indicates a form of self-enhancement described as rigid overconfidence [11]. According to Paulhus [11], high scorers on this scale tend to claim to "know it all," even when they are questioned about things they could not possibly know. Thus, this scale is measuring a kind of self-deception that involves a lack of insight [11]. This can be useful in the FFD examination, especially for understanding why an employee might not be getting along well with coworkers.

Case Examples

The following cases have been heavily masked so that employers and employees cannot be identified. The first two cases are younger adults but provide context and address issues that could just as readily occur in older adults.

Neuropsychological FFD Examination of a Government Agent with Traumatic Brain Hemorrhage

A 38-year-old female had experienced a fall, striking her head and suffering a subsequent bleed into the brain that affected the use of her right, dominant hand and altered her speech patterns. CT and MRI of the brain were both positive for the disturbance. The agency was concerned about her ability to handle a firearm. She was attempting to recertify for her firearms qualification after returning from medical leave, but she was struggling to do so. The agency asked for specific neuropsychological opinion about

her abilities related to motor and executive functioning and generally about her neurocognitive strengths and weaknesses. Her instructors agreed she was not proficient, as she was not taking instructions well and not loading and using her weapon with proficiency. Although she had improved in her abilities since the medical incident, the neuropsychological findings showed bilateral fine motor difficulties that were more pronounced on the right than the left, slowed processing speed, and word-finding difficulties with dysfluency. The examiner concluded that she would have difficulties in motor skills, judgment, and communication, particularly under stressful or fast-moving conditions and that her safety and the safety of her coworkers would be affected under these conditions.

Bank Employee with Progressive Cognitive Impairment

Employer was concerned about a 71-year-old female bank manager showing apparent memory problems. Neuropsychological evaluation showed evidence of short-term memory and executive functioning problems that would impair her performance at work. While she remembered crystallized occupational information related to technical financial information and she remembered her long-term customers, she had difficulty with fluid problem solving and memory functioning that included remembering what she had done for a customer, remembering new computer operations, and remembering what coworkers have told her. The examiner recommended a neurologic workup and potentially medications for memory decline, along with physician-approved exercise. Management already provided her with a memory book and a buddy system/partner to help in her work. One suggestion to extend her employment was to consider letting her bring in clients while someone else handles the computer work. Other suggestions included a daily checklist of tasks to perform and someone to log customer requests for her. Other than to have a full neurologic workup, medical leave (time off) was not recommended. However, it was made clear that it was not possible for this employee to perform all her work duties due to neuropsychological impairment.

Other Types of FFD Examinations

Federal Aviation Authority (FAA) – Pilot Examinations

The examination of pilots who have experienced psychological or neuropsychological pathology represents a specialized type of FFD examination. First, the examinations must adhere to FAA specifications that not only require specialized testing (e.g., Cogscreen; see http://www.cogscreen.com) but also rely on experience and knowledge concerning proper normative groups and the issues involved in subtle impairments that affect pilot performance. According to the Cogscreen website overview (http://www.cogscreen.com), Cogscreen is not a test of aviation knowledge or flying skills but a battery of neuropsychological tasks that measure the underlying visuomotor, perceptual, and information processing abilities associated with the operation of aircraft. Parenthetically, drone operation is now under the rubric of FAA medical specifications, and drone operators who have experienced psychological or neuropsychological pathology are required to undergo the same evaluations.

At the 4th Annual Aerospace Psychology Seminar in Denver, CO, Kay and Atkins [12] spoke on the specialized use of norms in FAA examinations, providing the hypothetical case of an 80-year-old pilot with 13 years of formal education. The hypothetical pilot responds correctly to 12 out of 20 math problems known to have a 10th grade level of math equivalence. This performance places this hypothetical older pilot at the 32nd percentile according to norms corrected for age and education but only at the 5th percentile compared to non-corrected norms. The authors go on to discuss pilot norms for typical neuropsychological tests and that Cogscreen has norms that relate specifically to pilot performance. The warning given, which has become lore in pilot examinations, is “there are no age-normed runways.” Indeed, we want our pilots

to be able to operate aircraft as competently as pilots who do not have any pathology. A comprehensive look at pilot psychological examinations can be found in *Aeromedical Psychology*, by Kennedy and Kay [13].

Licensing Board Examinations

The mission of all licensing boards is essentially the same: to protect the public from the misdeeds or incompetence of its licensees. This writer has conducted psychological and neuropsychological examinations for several different licensing boards, including medical, nursing, chiropractor, counselor, social work, and psychology boards. The FFD issues are similar for licensing board examinations (as well as pilot examinations), including positive impression management and normative issues. Indeed, one might extend the lore of pilot examinations to the highly skilled aspects of being a surgeon: "There are no age-normed scalpels." Thus, age norms that place the 85-year-old surgeon in the high average range for his age for tasks that involve fine visuomotor control (e.g., Grooved Pegboard) may actually be at a much lower level if the older surgeon were compared to their much younger counterparts.

Otherwise, the issues for licensing board examinations revolve around the same competency issues brought about by drug/alcohol abuse, psychological or emotional instability, medication use, and neurocognitive compromise (e.g., from stroke, seizure disorder, traumatic brain injury, etc.). The examiner will be providing the licensing board with specific opinion about psychological or neuropsychological impairment. While the psychologist must be careful not to provide opinion outside the scope of their own field, it is not uncommon to provide opinion about psychological or emotional stability with coworkers or patients or about the underlying neurocognitive components of fine motor skills such as might be required in surgical operations. As with any other FFD examination, these are medicolegal examinations in which clean boundaries between the examiner and examinee must always be apparent.

Clinical Pearls

- Fitness-for-duty examinations are a type of medicolegal evaluation in which the psychologist's client is the employer or an agency (FAA, licensing board).
- Clear boundaries are essential, and it must be clear that no typical doctor-patient relationship exists, though respect for the employee's dignity and person is offered.
- The purposes and nature of the evaluation must be specified to the examinee at the outset, and the fact that the findings may have adverse consequences for the employee must also be conveyed.
- In the process of informed consent, the nature of the evaluation is fully explained; in particular, the goal is to answer the employer's questions about the employee's psychological or neuropsychological functioning as to whether it has an impact on the workplace.
- Validity issues mostly have to do with positive impression management and consequent underreporting in which the absence of evidence of pathology does not constitute evidence of absence of pathology.

Acknowledgment The author wishes to thank Dr. David Fisher, who provided helpful comments and suggestions, and Paige Haley, for her work on the final manuscript.

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