Magnetic resonance imaging and litigation—Who is driving?

I am a lawyer. Initially, I was a bit uncomfortable with the idea of writing about MRIs for an audience of doctors. However, I believe this discomfort arises from an issue that should be addressed.

Over the past number of years, MRIs have attracted the attention of the legal community. And occasionally, lawyers can appear to be the driving force behind medical testing or treatment. Some lawyers may view MRIs as an exciting "high tech" tool that provides more information than X-rays or CT scans. The difficulty, of course, is that most lawyers cannot interpret MRIs, X-rays, or CT scans.

Using the example of a back injury, I am told by some medical experts that a large percentage of symptom-free patients will, nevertheless, have abnormalities or peculiarities within the back identified on an MRI. It therefore seems that there may not always be a strong correlation between MRI findings and any demonstrable injuries.

What, then, does an MRI provide if the driving force behind the procedure is a lawyer rather than a doctor? Certainly, the MRI could provide the basis for an argument that any abnormalities must have been caused by the defendant in the litigation. This provides an incentive for a lawyer to request a private MRI for their clients to assist in litigation. The difficulty for the lawyer is that we cannot arrange for such an MRI without a doctor's referral. The question for the doctor is whether it is appropriate to accommodate the lawyer's request that an MRI be obtained.

The BC College of Physicians and Surgeons may have considered this type of situation when preparing its online *Resource Manual for Physicians* in respect to referrals. The College states that "Physicians have an obligation, when reaching a decision on a medical service to be provided to a patient, to consider the medical necessity for that service and any resultant cost to society."[1]

The courts may allow the expense of a private MRI in a court action as a "special damage" (direct out-of-pocket expense) or as a "disbursement" (expense related to litigation) in certain circumstances.

The legal test for payment of any expense claimed as a special damage is its reasonableness. Similarly, a disbursement will be allowed when the expense was necessarily or properly incurred in the conduct of the legal proceeding. A medical recommendation for an MRI, for either treatment or litigation, has been accepted by the courts as sufficient to meet the test of the reasonableness of obtaining the MRI. For example, in *Colasimone v. Ng,* an MRI expense was allowed as a disbursement when a physician stated it would be medically helpful and necessary.[2]

Recent court decisions dealing with payment for private MRIs seem to show a convergence between the test of medical necessity mandated by the College and the court's test of reasonableness. The courts seem to require a medical foundation for an MRI before the expense can be recovered.

In *Parrotta v. Bodnar,* plaintiff's counsel argued that an expense for a private MRI used by an expert witness could be claimed as a disbursement. The registrar deciding the issue stated: "I think that in this particular instance I am going to disallow the MRI mostly for the fact that even though there was some suggestion that it be done, I do not think that there was any benefit. In fact the doctor herself says that she did not think the MRIs were going to show anything and in my view then there should have been consideration given as to whether or not the MRI should have been done in any event and she should have been questioned with respect to that."[3]

In *Ward v. W.S. Leasing Ltd.,* the court disallowed an MRI expense when it was plaintiff's counsel's standard practice to obtain MRIs for all personal injury clients. The registrar noted that: "A blanket conclusion that an MRI is necessary in every personal injury case renders the cost extravagant or as a result of excessive caution or zeal, as that language was used in *Van Daele v. Van Daele*. In my view there must be some judgment applied, perhaps with medical input, in considering the necessity for the procedure in a litigation context, given the injuries involved, the likely damages, what the MRI is expected to achieve from a litigation standpoint, and so on. There is no proper basis on which I can conclude that the MRIs were necessary, at the time they were ordered, in this particular case."[4]

In *Phelan v. Newcombe,* plaintiff's counsel's position was that "the more tests you do the better." The court rejected the expense, stating: "Here, although [counsel] said that he does not order MRIs in every one of his cases, the necessity for the MRIs in this case was simply not made out. A CT scan had just been conducted (and there was no evidence to show that an MRI would have captured things not shown on the CT scan), it was very early on in the injury recovery process and no medical practitioner had recommended that MRIs be done. In general, disbursements that are incurred

based on reasoning that is equivalent to "just in case" or "you never know" will not be found to have been reasonably incurred or, to put it another way, they will be found to be extravagant or the result of excessive caution or zeal."[5]

Conclusion

The courts seem to allow a private MRI expense when it is seen to have been reasonable either in treatment or in litigation, and was obtained with some level of medical input. The College requires doctors to "consider the medical necessity" in requesting MRIs. Perhaps the apparent convergence of these two tests will assist both doctors and lawyers in deciding whether there is a need for an MRI in the litigation context.

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Disclaimer

This article is intended to provide general information only and should not be relied on as legal advice. Any specific questions readers may have about their legal rights and obligations should be referred to the reader's own legal advisors.

References

1. College of Physicians and Surgeons of British Columbia. Resource Manual for Physicians. www.cpsbc.ca/cps/physician_resources/publications/resource_manual/referaldoc (accessed 3 June 2008).
2. *Colasimone v. Ng.* 2007 BCSC 1179, paragraphs 22-24.
3. *Parrotta v. Bodnar.* 2006 BCSC 787, paragraph 13.
4. *Ward v. W.S. Leasing Ltd.* 2007 BCSC 877, paragraph 14.
5. *Phelan v. Newcombe.* 2007 BCSC 714, paragraph 16.

Group medical visits: Enhancing chronic illness care

An "impressive tool for change" is how Dr Judy Dercksen describes group visits—one of four modules offered by the General Practice Services Committee's Practice Support Program (PSP).

The Quesnel GP, who practised in South Africa until 5 years ago, first learned about group visits at an Institute for Healthcare Improvement (IHI) conference in the US. She was immediately taken with the approach, which puts chronic disease patients together for medical visits—and in the process improves access to medical appointments, uses resources more efficiently, helps motivate behavior change, and ultimately improves outcomes.

"The vast majority of my diabetes patients—some of whom have been very resistant—have made noticeable changes in their lifestyle," says Dr Dercksen.

Who can participate?

A group medical visit includes several patients with the same or similar chronic conditions who meet with a health care team that consists of two or more of the physician, medical office assistant, nurse, dietitian, or specialist. Candidates for group visits are patients with chronic illness or particular problems (e.g., diabetes, blood pressure management) who need regular monitoring, patients in a specific age group (e.g., frail elderly), and patients who might benefit from a support structure. Group visits allow patients to learn from providers as well as from other patients. There's more time to address psychosocial issues, which in turn helps patients put their illness into perspective and boosts their confidence in their self-management abilities.

Enderby GP Dr Allison Rankin says group visits would work in any practice with complex or elderly patients, or those with comorbidities. "Let's face it—these days, that's most practices," she says.

Dr Rankin also learned about group visits at an IHI conference, and is now a GP champion on Interior Health's PSP team. In that role, she will mentor her colleagues participating in the group visit module.

Group visits: Coming soon

PSP group visit modules will soon be available in all health authorities. The sessions will enable practices to identify the group visit model that will work best in that practice, identify patient populations, plan, conduct, and evaluate group visits, and identify patient issues and outcomes.

"There is no set recipe for group visits—my team has tried a few different ways," says Dr Rankin. Her most recent sessions—with chronic pain patients—have been extremely successful. She has just completed her fifth session and the group is at the point of exchanging contact information with each other, sharing resources, and arranging for other participating health professionals for upcoming sessions.

"I was at the point where I thought I couldn't help my pain patients," says Dr Rankin. "But when you put them together in a group and they can support each other as well as get the medical attention they need, things really turn around."

Medical care is always part of the visit, says Dr Rankin. "Patient evaluations, necessary lab tests or physical exams, and updating of charts and

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