THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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Dealing With Wash-Out Reports

"In taking a Wash-Out doctor's testimony it is important to look at each source of data and examine the contents of their report in each area to see if the doctor reported sufficient information in each of the five possible areas to support a conclusion one way or the other. The way to do this is ridiculously simple."

I pointed out in last month's newsletter that I have been doing forensic psychological evaluations for personal injury and workers' compensation for 28 years. In doing so I have had a lot of fun, found the work challenging and learned a lot. One of the first things I learned was that were some doctors who never found a disorder and never concluded the plaintiff or applicant had a psychiatric injury. These physicians are politely called Wash-Out doctors. In the military, a Wash-Out is a candidate for a program such as the Army's Green Beret's or the Navy's Seals who fails to meet the programs requirements and is "washed out" or dropped. In personal injury or workers' compensation litigation a Wash-Out refers to a doctor's report that finds that the "patient" fails to meet the criteria for having suffered a psychological disorder or injury and is therefore "washed out" of consideration for such a conclusion. As discussed in last month's newsletter, a Wash-In refers to a doctor's report that concluded that the patient had a disorder despite the fact that there are little or no data supporting that conclusion.

Wash-Out and Wash-In doctors can still be found in personal injury litigation. As I pointed out last month, the same is not currently true in workers' compensation cases. In the "old days" of workers' compensation in California, before SB899 in 2005, many medical-legal doctors were often referred to as "Wash-Outs" or "Wash-Ins" because they would either never find a compensable disorder or would always find a compensable disorder, respectively, regardless of the patient's presentation. Since January 1, 2005, with the installation of Panel Qualified Medical Evaluators and the increased use of Agreed Medical Evaluators there are no explicit "Wash-Out" or "Wash-In" doctors. However, some AME's and PQME's still provide some "Wash-Out" and "Wash-In" reports. These doctors generally have a few select attorneys who they provide reports that are "overly generous" in finding psychiatric injuries, estimating permanent disability and drawing conclusions about apportionment. These same doctors also have defense attorneys who they provide reports that are "stingy" in finding psychiatric injuries, estimating permanent disability and arriving at apportionment opinions. It is only when they get a case from both sets of attorneys that they have to be careful with what they say. However, in workers' compensation in some states, and in personal injury litigation, there are still "Wash-Out" or "Wash-In" doctors.

Last month I talked about how to cope with a "Wash-In" report, namely how to take a doctor's deposition or trial testimony in such a way as to expose the lack of credibility of their report, which usually means embarrassing the doctor along the

way. I mean really, don't they deserve that? This month I'll talk about how to do the same thing to a "Wash-Out" report and doctor.

Let's start out by assuming that the person who has been evaluated has actually had a psychological disorder and has a psychiatric injury in the form of a diagnosable disorder using the appropriate American Psychiatric Association's diagnostic manual. What does the doctor have to do to "Wash-Out" a patient who really has a disorder? Quite simply, the doctor has to turn a deaf ear to the data, usually by not providing all the information needed to come to a reasonable conclusion.

In this regard, it is important to understand that psychological diagnoses are made after considering as many as five different sources of information. These sources of information are: the patient's life history and their presenting complaints or symptoms, the doctor's report of their face-to-face Mental Status Examination, the objective psychological testing data, the patient's medical records and any collateral sources of information in the form of interviews with the patient's friends, relatives and/or co-workers that are available at the time the doctor examines the patient.

In taking a Wash-Out doctor's testimony it is important to look at each source of data and examine the contents of their report in each area to see if the doctor reported sufficient information in each of the five possible areas to support a conclusion one way or the other. The way to do this is ridiculously simple.

First, you go to the doctor's description of the patient's current symptoms or complaints; those terms are synonymous. In this regard, the doctor who has chosen to report that the patient does not have a diagnosis should provide you with information about how the patient's complaints or symptoms were obtained. Obviously, if I wanted to Wash-Out a patient and did not care one iota about ethics, all I would have to do is say, "Ms. Smith, how are you doing today?" In fact, I typically ask that of every examinee I meet and can tell you that the vast majority will say something like, "OK," "Fine" or "I've been better." If the doctor accepts that "history" at face value, they can report that the patient had no complaints or symptoms. Clearly, this is an extreme position but one does not have to be very creative to find some middle ground positions that will yield the same bottom line.

In fact, when a doctor finds no symptoms or complaints indicative of a disorder, I believe it is their responsibility to tell the reader of their report how those data were obtained. For example, in cases in which I have found no disorder I will always put in a discussion describing how I took the patient's history. Here's what I typically say,

"Ms. Smith, the first thing we need to do is get a complete history of your current symptoms or complaints. By current symptoms or complaints I mean anything that has been bothering you either physically or psychologically in approximately the last month. Now we're going to start off by simply making a list of those complaints. At first, I don't want us to talk about them in detail. All we need to do is make the list and then we'll go back and talk about each one in detail. And, don't worry about forgetting to put something on your list. We'll be meeting for about two hours or possibly more and if you forget to put something on your list and it comes out at any time during our meeting, we'll just add it to your list. Do you understand?"

Next, after the list is completed, I go through each symptom or complaint asking the patient to describe the frequency, intensity, duration, onset and course over time. That is what it means to take a complete psychological history. If there are no data in the "Wash-Out" doctor's report that indicate that he or she has asked those questions and provided the answers in their report, then that report is lacking data, information or support for the finding that the patient was not psychologically disordered when

examined by the doctor. Of course, during the taking of the doctor's deposition or trial testimony, the attorney can be expected to ask the doctor, "Dr. Jones, will you please tell me exactly how you took Ms. Jones's history of her current symptoms or complaints at the time of your examination?" Or, since I always recommend not asking the doctor about the patient during a deposition or trial, but confining one's questions to the doctor's report, "Dr. Jones, will you please tell me exactly where in your report I can find a description of the manner with which you obtained information about Ms. Jones's history of her current symptoms or complaints at the time of your examination?" Obviously, the most important question is, "Where are the data?" Clearly, this is not rocket science, just common sense!

The second set of data that a doctor uses in making a psychological diagnosis is their report of their Mental Status Examination. A Mental Status Examination produces a set of observations of the patient, which are made by the doctor during a face-to-face clinical interview, using a relatively standard set of examining techniques and questions. An outline of a Mental Status Examinations can be found in any one of the many classic books about these examinations (e.g., Trzepacz, P. T. and Baker, R. W. The Psychiatric Mental Status Examination, Oxford University Press. Oxford. 1993). This book clearly outlines the data that the doctor should provide in their report about the claimant's appearance, attitude, activity, mood, affect, speech and language, comprehension, thought content, memory, attention, insight, and judgment. All of these behaviors can be described in easy to understand terms. In many cases there are simple procedures that can be employed during the taking of a Mental Status Examination that produce easily reported upon objective data. For example, if the doctor wishes to do so they can test a patient's memory with a variety of techniques some as simple as pointing out three or four objects in the examination room and asking the patient to recall them after an interval of perhaps five minutes. If the doctor did not obtain and report upon observational data in all of the above-described areas, there are no data in their report indicating that they administered a professional and credible Mental Status Examination. Again, the most important questions is: "Where are the data?"

The third set of data are the psychological testing results. Psychological testing data are typically the only form of objective information that can be presented to the court in the form of publicly accessible numerical scores. There are literally thousands of psychological tests. Unfortunately, most of them are worthless in medical-legal evaluations. The reason for this is quite simple. With minimal exceptions, most psychological tests are subjectively interpreted. For example, one type of common test is a Sentence Completion Test. In this test, the patient is given the first few words of a sentence and asked to complete the sentence in any way they deem appropriate. There are usually a relatively large number of items administered to the patient. The doctor then interprets what the patient's productions mean. Unfortunately, there are no standards for interpreting these tests, just as there are no standards for asking a patient to draw a picture of a person and then interpreting the drawing. The doctor can say it means anything that they want it to mean. Thus, if the doctor is intent on not finding a disorder they will provide a benign interpretation and conclude that there are no testing data indicative of psychopathology. "If you do not seek, you will not find."

However, the above methods of psychological testing do not represent the state-of-the-art. For almost 70 years there has been an effective alternative. That alternative is to use one of the three forms of the Minnesota Multiphasic Personality Inventory (MMPI), or some similar test to evaluate adults embroiled in litigation. These tests all have in common the ability to provide the doctor with validity scale scores that indicate if the patient took the test in an honest and forthright manner or was trying to portray themselves in an unrealistically favorable light or exaggerating, embellishing, over-reporting or attempting to simulate symptoms. If the data indicate they were honest, do the clinical scores support the diagnoses provided by the doctor? Alternately, are all the clinical scale scores within the normal range, which support the conclusion that there was no psychopathology? This is very simple. None of the conclusions are subjective as there are thousands of peer-reviewed journal articles and probably hundreds of books describing the extensive body of research indicating what the validity and clinical scores mean. If the person is truly psychologically healthy and has no psychopathology, the scores will demonstrate that fact. No scores? Well, that's a problem.

Fourth, you look at the doctor's review of the medical records. At that point you ask the simple question, "Did the doctor cite any credible medical records that support their diagnostic conclusions?" Have other doctors found some psychopathology? If so, what is the basis for the "Wash-Out" doctor's disagreement? If the other doctors have done their job properly there will be data in their reports supporting their conclusions. What does the "Wash-Out" doctor say that makes one believe that the data found in the medical records are not credible?

Fifth, you check to see if the doctor has cited any collateral sources of information in the form of interviews with the claimant's co-workers, friends and/or relatives who have offered information that could shed some light on the claimant's psychological status. However, don't hold your breath looking for collateral sources of information in psych reports because it usually isn't there. In fact, collateral sources of information are typically used only when the examinee is unable to provide a cogent history as might be the case with someone who is suffering from a psychotic disorder with hallucinations and/or delusions or someone who is severely developmentally disabled and cannot speak about their feelings, thoughts and behaviors with any clarity.

The last and final step is the most important. What specific questions do you ask the doctor that reveals they did not do a reasonable job in collecting and reporting on information that would reveal psychopathology? Obviously, that depends on the patient and the doctor's report. Generally, what an applicant attorney should do during a deposition is ask questions about how the data were collected and where in the doctor's report one can find information supporting their conclusions. Clearly, proving the negative, which is that there is no disorder or disability, has some conceptual drawbacks. However, it is the doctor's responsibility to provide the data and when they have not done so the situation can be very embarrassing for the doctor and extremely rewarding for the patient's attorney and their client.

This is the sixty-third of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.