THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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Dealing With Wash-In Psych Reports

I've been doing forensic psychological evaluations for personal injury and workers' compensation for 28 years. During that time I have read untold thousands of medical-legal reports from psychologists and psychiatrists. It's been a tremendous learning experience and ultimately much more challenging and exciting than the overlapping 30 years I spent as a fulltime college professor. As I pointed out in my December, 2013 newsletter, many of the reports that have darkened my door fall into one of two categories: Wash-In reports and Wash-Out reports.

Wash-in reports are those in which the doctor has concluded that the patient has a disorder or suffered a psychiatric injury despite that fact that there are little or no data supporting that conclusion. Wash-out reports are those in which the doctor has concluded that the patient does not have a disorder or a psychiatric injury despite the fact that their report cites little or no data indicating that the "patient" is psychologically normal.

This month I will discuss how to take deposition or trial testimony from a doctor who has written a Wash-In. Next month I'll talk about how to cope with Wash-Out reports.

While the principles discussed in this newsletter apply to the entire English-speaking world, some of the specific laws cited are applicable only to the California workers' compensation system and may not be relevant in your jurisdiction.

One of the first things that was evident to me in year one of my private medical-legal practice, 1985, is that there were Wash-Out doctors who never found a disorder and there were Wash-In doctors who always found a disorder. The first thing to be said about these physicians and their reports is that the current situation is different in workers' compensation and in personal injury cases. Essentially, the old system of two types of doctors is still present in personal injury cases, namely that attorneys and adjusters can find both types of physicians. The same is not entirely true for the workers' compensation arena.

In taking a Wash-In doctor's testimony it is important to look at each of their diagnoses and examine the contents of their report to see if there is sufficient information to support those diagnoses. The way to do this is ridiculously simple.

With regard to workers' compensation, let's recall that in the old days, before January 1, 2005, each applicant and defense attorney could get their own medical-legal reports. This created some defense-oriented doctors who specialized in Wash-Outs and some applicant-oriented doctors who specialized in Wash-Ins. Obviously, the Wash-In doctors cultivated their relationships with the applicant attorneys and the Wash-Out doctors cultivated their relationships with the defense attorneys and insurance adjusters. Then in 2005 came SB 899 and the rise of the Panel Qualified Medical Evaluation and the increase in popularity and need for Agreed Medical Evaluators. No longer was each attorney allowed to get their own medical report. This ended the "dueling doctors" era and created an employment problem for the Wash-In and Wash-Out doctors.

From my point of view, the situation was rather rapidly resolved. Specifically, despite SB899 there are still Wash-Out reports and Wash-In reports although

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when it comes to AME's and PQME's there are no all out, fulltime, Wash-Out or Wash-In doctors. However, some AME's and PQME's have adopted a strategy that allows them to provide Wash-Out and Wash-In reports to different sets of attorneys. Specifically, some doctors have a select few applicant attorneys who they provide reports that are most politely described as "overly generous" in finding industrial injuries and estimating permanent disability. These same doctors also have defense attorneys who they provide reports that are "overly stingy" in finding industrial injuries and estimating permanent disability. It is only when they get the same case from both sets of attorneys that they have to be careful with what they say and walk a fine line so as not to offend or alienate either party.

Now, as I pointed out in my December, 2013 newsletter, virtually every attorney knows when they have been "had" in a psychological report that either provides an over-diagnosis or an under-diagnosis and comparable estimates of causality, permanent psychiatric disability, apportionment, and a need for treatment. As noted above, this month I'll talk about Wash-In reports where the defense attorney knows that the doctor has over-diagnosed and provided incorrect and overly generous conclusions about all of the above-mentioned issues.

Let's assume that you are a defense attorney and your client has received a report in which the claimant has been diagnosed with a psychological disorder that was produced by the event under litigation and that the doctor has gone on to report that the claimant has some permanent psychological impairment and is in need of treatment. Let's also assume that for one reason or another you are correct in believing that the doctor wrote a Wash-In. How do you prove it when taking the doctor's deposition or trial testimony?

The essence of exposing a Wash-In during a deposition or trial testimony invariably comes down to the doctor's diagnosis. Specifically, in psychological and psychiatric reports the keystone is the doctor's diagnoses. Accordingly, since the DSM-5, which was published in May, 2013, has not been widely accepted as a credible and useful diagnostic manual for reasons outlined in my January, 2014 newsletter, the DSM-IV-TR is still the standard. Thus, for Wash-In reports, in the absence of one or more credible DSM-IV-TR diagnoses, it is not reasonable to conclude that an applicant has had a psychiatric injury. Accordingly, if it can be demonstrated to the court that there are insufficient data to warrant the correct diagnosis of a psychological disorder it becomes apparent that it is not reasonable to conclude that the claimant has had a psychiatric injury, a psychiatric disability or a need for treatment.

In taking a doctor's deposition or trial testimony I believe that it is important to keep a number of things foremost in your mind. The first is that DSM-IV-TR diagnoses are clearly empirically defined in that diagnostic manual. They are also empirically defined in the DSM-5 but the DSM-5 is very explicit in stating that it is completely permissible for the doctor to entirely ignore the diagnostic criteria in drawing their conclusions. Accordingly, the credibility of any report hinges on the correlation between the doctor's data and the diagnostic criteria. Sticking with the DSM-IV-TR, that manual requires that specific diagnostic criteria be met and if there are no data in the doctor's report meeting those criteria, then the doctor's diagnosis is not supportable. Exactly like a house of cards, once the doctor's diagnosis is dismissed, all of the conclusions resting on that diagnosis are unsupportable.

Essentially, it is important to understand that DSM-IV-TR 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, 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-In doctor's testimony it is important to look at each of their diagnoses and examine the contents of their report to see if there is sufficient information to support those diagnoses. The way to do this is ridiculously simple.

First, you go to the DSM-IV-TR and get the diagnostic criteria for each disorder diagnosed. Once having done so you read the doctor's report to see if their history of the claimant's symptoms or complaints provides sufficient information to warrant the diagnosis. This is not rocket science! Since the DSM-IV-TR is written in reasonably non-technical English

all one has to do is compare what the doctor has said about the patient's complaints with the disorder's definition in the diagnostic manual.

Second, you read the doctor's report of their Mental Status Examination. An outline of a Mental Status Examination can be found in the Psychiatric Protocols, which is used for injuries occurring prior to January 1, 2005. You can also read about the nature of Mental Status Examinations in one of many of the classic books in this area (e.g., Trzepacz, P. T. and Baker, R. W. The Psychiatric Mental Status Examination, Oxford University Press. Oxford. 1993). This book clearly outlines the nature of a Mental Status Examination and describes 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 administration of a Mental Status Examination that produce easily reported upon objective data. For example, the doctor 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 there are no data in the doctor's report of their Mental Status Examination supporting the doctor's diagnosis then either the diagnosis is flawed or, as might be true in the case of a Sleep Disorder or a Panic Disorder, it might not be possible to observe the psychopathology during a face-to-face clinical interview.

Third, you look at the psychological testing data. Given that we are talking about a medical-legal examination, the first thing that must be determined is the patient's credibility. The major psychological test for providing objective information about that credibility is one of the three forms of the Minnesota Multiphasic Personality Inventory (MMPI) used to evaluate adults. Here the first question to ask is: "Has the doctor provided validity scores that indicate that the patient took the test in an honest and forthright manner and has not produced validity scale scores that indicate they were trying to portray themselves in an unrealistically favorable light, exaggerating, embellishing, over-reporting or attempting to simulate symptoms?" If the data indicate the applicant was honest, the next question to be answered is: "Do the clinical scale scores support the diagnoses provided by the doctor?" This is very simple to determine although an attorney not familiar with the MMPI may need some professional assistance.

As an aside, it should be noted that unfortunately, many of the tests that are frequently found in psychological reports are either subjectively interpreted, such as the Draw-A-Person Test in which the patient is asked to draw a person and the doctor comes up with their own subjective conclusions about what the drawing shows. Similarly, another commonly used test that is subjectively interpreted and has no known use in medical-legal evaluations is any of the many Sentence Completion Tests in which the claimant is given a few words and asked to complete a sentence using those words. Again, the doctor subjectively interprets the completed sentences with no known standards or meanings attachable to the claimant's productions.

Fourth, it is necessary to read 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?"

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, there is really no need for such information in the vast majority of the cases since the other four sources of data are sufficient.

Now, above all, the most important rule for an attorney to follow during a deposition or a trial is: "Never ask the doctor about the applicant!" All of your questions should be directed at the doctors'

report. The reason for this is quite simple. If you ask the doctor about the applicant they can feel free to provide information that is not in their report that may justify some of their conclusions. Obviously, that information may or may not be correct for a variety of reasons. However, if you confine your questions to what is in the report, no new "evidence" can find its way into the testimony and your outcome will most likely be far superior.

The last and final step is the most important. What specific questions do you ask the doctor that reveals the claimant does not have the disorder diagnosed by the doctor? Obviously, that depends on the disorder and the doctor's report. However, when done correctly it can be a very embarrassing situation for the Wash-In doctor and an extremely rewarding experience for the attorney. If you want some useful questions that fit into an effective strategy I'll be very happy to provide you with one or more sample reports written for attorneys who are about to take a doctor's deposition or trial testimony. Those reports analyze the doctor's diagnosis, compares each diagnosis to the DSM-IV-TR, summarizes the most substantial flaws and provides sample questions specific to that doctor's report. Just call or write my office and I'll send them to you for your analysis. Another option is to look at my February, 2013 Newsletter titled, "Forty Tough Deposition Questions," which you can find at www.DrLeckartWETC.com.

DON'T FORGET, NEXT MONTH I'LL TALK ABOUT THE OTHER SIDE OF THE COIN, WASH-OUT REPORTS AND HOW TO DEAL WITH THEM.

This is the sixty-two 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.