THE WETC PSYCHOLOGY NEWSLETTER

Dr. Bruce Leckart

Westwood Evaluation & Treatment Center, 11340 Olympic Boulevard, Suite 303,
Los Angeles, California 90064, 310-444-3154, DrLeckartWETC@gmail.com

February, 2010
Volume 1, Issue 13

Common Flaws in Psych Reports #2

Litigation is obviously an adversarial procedure. As such, both sides look for flaws in the opposition's case that may result in what they feel is a clearer picture of the situation that will ultimately benefit their client. When it comes to expert witness testimony, whether it is in a personal injury matter or a workers' compensation case or whether the doctor is appearing in court, being cross examined during a deposition, or has simply written a report that the court can depend on, it is very important that there not be some obvious and substantial flaws in that document or the doctor's testimony. If substantial flaws do exist, it is equally important that those flaws are identified.

Last March I wrote a newsletter about substantial flaws that can be found in most psych reports written for personal injury and workers' compensation litigation. The identification of report flaws is an especially thorny problem for attorneys and adjusters in the workers' compensation area since the passage of SB899 has resulted in a situation where most AME reports are not reviewed by other mental health professionals who are capable of finding those errors.

In March, 2009 I pointed out that three of the most frequent report errors are:

1. A lack of correspondence between the history presented by the doctor and the DSM-IV-TR diagnostic criteria.

2. A lack of correspondence between the Mental Status Examination data presented by the doctor and the DSM-IV-TR diagnostic criteria.

Email us:

DrLeckartWETC@gmail.com

"The identification of report flaws is an especially thorny problem for attorneys and adjusters in the workers' compensation area since the passage of SB899 has resulted in a situation where most AME reports are not reviewed by other mental health professionals who are capable of finding those errors."

3. The failure to provide objective psychological test data supporting the doctor's diagnosis.

This month's WETC Newsletter discusses one additional flaw in psych reports in the hope that this information can be used by non-mental health professionals to identify such flaws in time for an MSC or during an AME's deposition or trial testimony.

Statements Doctors Make Indicating They Have Not Collected Enough Data to Make a Diagnosis

In my initial newsletter of common flaws in psychological reports I talked about the issue of doctors not collecting or providing sufficient information to support their diagnosis. Often this can only be ascertained by looking at the DSM-IV-TR diagnostic criteria and checking to see if the doctor has sufficient history, Mental Status Examination data and testing data to support their diagnostic conclusions.

However, in addition to the above, there are many times where the doctor will directly state that they have not obtained sufficient information to make a diagnosis. When put into "professional language" these statements are sometimes not easily detected.

One way a doctor has of admitting that they have not collected enough information to understand the patient's psychological status is to use a "vs." diagnosis. For example, the doctor may "diagnose" a "Depressive Disorder Not Otherwise Specified vs. a Major Depressive Disorder." In simple language

this is the same as saying, "I'm not sure which of these two disorders the patient has." While the doctor is stating their opinion that the patient is clinically depressed, by using the concept "vs." in providing their diagnostic conclusions they are stating that there is ambiguity or uncertainty in their diagnosis. This is simply an indirect way of stating that they do not understand the patient and/or their condition. Generally, the doctor never explains why he or she is not certain of their diagnosis, nor does the doctor state why he or she did not obtain additional information to reduce the ambiguity. However, what is clear is that the diagnostic uncertainty created by using the term "vs." represents a substantial flaw in that document.

"Rule-Out" diagnoses are another way doctors have of stating that they do not understand the patient. For example, in providing their conclusions a doctor may state, "Rule-Out a Generalized Anxiety Disorder." In this regard, a "Rule-Out" diagnosis is simply a statement that they would like to eliminate or exclude the possibility of a Generalized Anxiety Disorder, but they have not yet done so. Typically, the doctor does not provide any insight or comment as to why they chose to write their report without having "ruled out" or "ruled in" the disorder, nor do they usually state what they plan on doing in the future to reduce the uncertainty. Nevertheless, it is quite clear that by using a "Rule-Out" diagnosis the doctor is stating that they do not understand the patient. Clearly, this is a substantial flaw in their report.

Another way to express diagnostic uncertainty and to admit to a lack of understanding of the patient is for a doctor to "defer" their diagnosis. "Deferred" diagnoses may appear on Axis I as well as on Axis II. According to the DSM-IV-TR, a "Deferred" diagnosis is only used when the doctor has "Information inadequate to make any diagnostic judgment" about an Axis I diagnosis or condition or an Axis II diagnosis. As is true with other types of expressed diagnostic uncertainty, in cases in which the doctor has chosen to defer their diagnosis they typically do not explain why they have done so, nor do they describe why they have chosen to write their report without obtaining adequate information. However, it is apparent that this form of diagnostic uncertainty also constitutes a substantial flaw in their report.

Additionally, diagnostic uncertainty can also be found in reports where doctors provide "Provisional" diagnoses. As noted in the DSM-IV-TR, the specifier "Provisional" is used when there is a strong presumption that the person will ultimately meet the full criteria for the disorder, but at the time of the doctor's examination there was not enough information to make a "firm diagnosis." While this type of reporting may be a reasonable way of communicating in a non-forensic case, it clearly reflects the doctor's admission that they do not understand the patient's condition. Once again, in a medical-legal context one must then ask why the doctor chose to write their report without obtaining the needed information to understand the patient. Under these circumstances the doctor who has chosen to do so can expect that their report will be criticized on this basis as containing a substantial flaw.

One final way in which doctors create diagnostic uncertainty is by introducing ambiguous terms in their formal diagnosis. For example, one recent report I read diagnosed "No clear personality disorder" on Axis II, the axis on which Personality Disorders are delineated. Unfortunately, the DSM-IV-TR does not recognize the term "clear," nor does it provide the doctor with this option. Specifically, in presenting an Axis II diagnosis the DSM-IV-TR allows the doctor only three options. First, they can diagnose a Personality Disorder or some form of Mental Retardation. Second, they may offer a "Deferred Diagnosis." And third, they can state "No Diagnosis on Axis II," indicating that the doctor has concluded that the person does not have a Personality Disorder and is not mentally retarded. In the above-mentioned case the doctor's use of the word "clear" in reporting "No clear personality disorder" indicates uncertainty in the doctor's diagnostic conclusion since it implies that a

Personality Disorder may be present, but the doctor was unclear or uncertain about its existence. As before, this raises the question as to why the doctor chose not to obtain sufficient data to reduce the uncertainty. Nevertheless, by not obtaining the needed data the doctor has introduced a substantial flaw in their report.

In summary, I have pointed out five ways that a doctor can introduce diagnostic uncertainty in their report by using vs., Rule-Out, Deferred, and Provisional diagnoses or adding ambiguous terms to an otherwise clear diagnostic statement. However, regardless of which of the five roads the doctor has chosen to take, once having done so they have revealed they lack an understanding of the patient, an obvious substantial flaw in a report headed for the scrutiny of the courtroom.

This is the thirteenth 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, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

Past Newsletters

February, 2009 –Litigation problems with the GAF
March, 2009 – Common flaws in psych reports
April, 2009 – The Minnesota Multiphasic Personality Inventory (MMPI)
May, 2009 – Apportioning psychiatric disability in workers' compensation cases and assessing aggravation in personal injury cases
June, 2009 - Subjectively interpreted projective psychological tests
July, 2009 – Sleep disorders and psychiatric injuries
August, 2009 – Posttraumatic Stress Disorder
September, 2009 – Computer Use Disorder
October, 2009 – Major Depressive Disorder
November, 2009 – The Millon Tests
December, 2009 – Psychological Factors Affecting Medical Condition
January, 2010 – Pain Disorders