TRAUMATIC BRAIN INJURY LITIGATION GROUP NEWSLETTER

Spring 2006

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Editor Comments

EDITOR'S COMMENT: "The best laid plans of mice and men...." (poet Robert Burns "To A Mouse" and John Steinbeck's Of Mice and Men. Yes, this is the Spring Edition of the TBILG Newsletter that I had intended to publish by June so you would have it before the convention in Seattle. My intention was to publish an article by Vivek Sehgal, M.D. of Detroit on imaging issues but, apparently these projects don't happen without the assistance of a resident who was "lost" for some reason. I think the project is still in the works and will hopefully be available in the near future. Plans are already underway for the Fall 2006 issue and your contributions would be greatly appreciated. Actually, there is reason to believe that the incidence of Traumatic Brain Injury has reduced over the last couple of years as our learned members don't seem to have many verdicts or settlements to share with their colleagues. In the absence of a case report, how about an article? Any interesting discovery issues? How about an issue dealing with neuropsychological testing? Please remember that this Newsletter is "ours" and unless you participate, it won't be very useful.

Finally, once again I would like to thank my assistant Toya Baldwin for assembling and producing this edition of the TBILG Newsletter. Stewart M. Casper, Casper & de Toledo LLC, 1458 Bedford St., Stamford, CT 06905, tel. 203-325-8600; fax 203-323-5970; email: scasper@cadetlaw.com ; www.casperdetoledo.com

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Diffusion - Tensor Fiber Tractography: Intraindivudual Comparison of 3.0T and 1.5T MR Imaging[1]

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The following article appears in the February 2006 edition of "Radiology". Regrettably the Radiolological Society of North America does not grant permission to reprint articles from "Radiology". However, this article is commended to your attention. The article underscores the advances made in the use of high field –strength magnets in MR imaging in clinical settings. The purpose of this reported study was "to prospectively evaluate the depiction of the brain fiber tracts at 3.0-T versus 1.5-T DT fiber tractography performed with parallel imaging.

The study population comprise 30 healthy subjects equally distributed by gender, with a mean age of 28 and no prior history of neurologic injury or psychiatric disease.

The authors concluded "that DT tractography at 3.0-T enabled improved visualization of the corticospinal tract compared with DT tractography at 1.5-T, and 3.0-T tractography of the superior longitudinal fasciculus, corpus collosum, and fornix has some advantages over 1.5-T tractography. Advances in efficient MR sequences are needed to improve the image quality and reliability of 3.0-T DT tractography". Radiology. 2006 Feb;238(2):668-78 at 677, Epub 2006 Jan 5.

Diffusion-tensor fiber tractography: intraindividual comparison of 3.0-T and 1.5-T MR imaging.

Okada T, Miki Y, Fushimi Y, Hanakawa T, Kanagaki M, Yamamoto A, Urayama S, Fukuyama H, Hiraoka M, Togashi K.

Department of Diagnostic Imaging and Nuclear Medicine, Graduate School of Medicine, and Human Brain Research Center, Kyoto University, 54 Kawahara-cho, Shogoin, Sakyo-ku, Kyoto-shi, Kyoto 606-8507, Japan.

PURPOSE: To prospectively evaluate the depiction of brain fiber tracts at 3.0- versus 1.5-T diffusion-tensor (DT) fiber tractography performed with parallel imaging. MATERIALS AND METHODS: Institutional review board approval was obtained, and each subject provided written informed consent. Subjects were 30 healthy volunteers (15 men, 15 women; mean age, 28 years;

Defense position: Bowers claimed the collision was entirely the fault of Buzzetta for running the stop sign. Buzzetta denied running the stop sign, and claimed that since she had nearly cleared Bowers' lane of traffic, it was Bowers who failed to keep a proper lookout and yield the right-of-way. It was also argued that this was an unavoidable accident.

On damages, both defendants argued that Nicolas did not need the level of care suggested by the life care plan but offered no evidence on damages.

Unusual legal issues or interesting trial techniques or happenings:

The parties consented to a bifurcated trial. During liability phase the only defense witness to take the stand was defendant Buzzetta. During her testimony she claimed that the sight lines between her vehicle and Bowers' were not clear. Following this testimony at the end of the first week of trial, plaintiff's had an engineer go to the scene to document on video the views Bowers and Buzzetta would have had of each other as they approached the intersection on the night of the wreck, and called him to testify in rebuttal the following morning. After less than an hour of deliberation, the jury returned a verdict finding both drivers responsible for causing the collision.

In the damages phase of the trial Nicolas' pediatric neurologist, a life care planner, an economist and his father all testified. The defense offered no proof in this part of the trial. The jury deliberated again for less than an hour before returning a verdict for $10,000,000.

Post trial disposition: Post trial motions are pending.

ARTICLES

Myths of Malingering

by Dorothy Sims, Esq.
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As many of you know, my practice is limited to cross examining doctors for other lawyers throughout the U.S. I got into this narrow line of practice when I became outraged at the outrageous and frequent claims by the defense that my clients were malingering (translation: Your client is committing insurance fraud, a third degree felony)

So, I then spent years studying and taking the tests only to discover a complete lack of science in every single "malingering test" utilized.

I deposed the authors of some of these tests to find out how they came up with them in the first place.

I watched hours of these tests being administered to my clients.

I took them.

I even had my own neuropsychologists take them.

As a result of this investigation I've prepared some suggested questions when dealing with malingering.

Basic science mandates that a normative sample cannot be applied to your client unless your client was adequately represented in the normative sample. For example, if a drug manufacturer researched a new antidepressant and used 200 middle aged men in the sample and determined a good dose to be 50 mg per day, that same dose cannot be applied to an infant. Why? Because infants were not represented in the normative sample.

The same is true with malingering. There are no studies I am aware of which actually included real malingerers. They include, instead, individuals who take tests and are told to behave as though *they believe* malingerers would behave.

Think about it for a minute.

How do malingerers behave? Who knows? How can we assume that someone who is told to behave like a malingerer will, in fact answer the same questions in the same manner, speed, and pattern as a true malingerer?

If someone attacks the science of the underlying studies and has a patient and bright judge, he or she may walk away with an order striking the reliance on malingering tests as failing basic scientific validity requirements (Please note, I have a transcript of such a case available by email)

Furthermore, most states preclude one witness from commenting upon the credibility of another. Isn't that exactly what the doctor is doing? (I have a motion I am willing to give out on this as well)

Malingering Questions in General.

Doctor, identify please, for me, which exact symptom my client is malingering? (*He will be vague. Make him give you one. He can't)*

Doctor, please identify all exact statements and all specific answers to specific questions your tests that are malingered. *(He can't.)*

Doctor, you mean out of the 2,000+ answers/responses that my client gave you in two days of testing you cannot come up with a single malingered answer?

Please show me in the testing manual where it permits you to conclude intentional fabrication or malingering based on these scores.

Doctor, isn't it true that, scientifically, in order for an experiment to be accurate and applied toward individuals, that experiment must contain like-minded individuals. For example, if you do a test on whether Motrin is effective for headaches for adults, you certainly would not apply the same dosage to children?

Doctor, are you aware of an article entitled *Did you think it was going to be easy-Some methods or logical suggestions for investigation development of malingering detection techniques* by David Faust and Margaret Ackley? The book, Detection of Malingering During Head Injury Litigation edited by Reynolds, Plenum Press, NY 1998 in which they stated that "none of the malingering tests that were created *(most of the doctors who create malingering tests are defense doctors)* contain actual individuals from the normal sample that are true malingerers?

Doctor, every single malingering study that has been conducted, none of them, none of them, contained actual true malingerers, because if we knew how to identify malingerers, we wouldn't be needing to do the study in the first place? In fact, these studies were created by typically having college students pretend to act as though they believed malingerers would act?

Isn't that a problem *(I would order the book, and turn to page 28, which states that there are at least two major ways in which real life malingerers might differ from subjects and studies such as college students instructed to fake bad? Real malingerers might be more skilled than research subjects.... and they may differ in kind or along with a number of qualitative features.....as another example, research subjects may be more likely to exhibit delayed reaction times when instructed to lie, because lying may not be habitual with them or they may be trying out a particular story for the first time or if malingering really does show a strong association with sociopathy (enhanced with various other features of sociopathy) studies of college students faking bad would probably never uncover such relations. Bottom line on that is, it appears as though the tests involving college students being told to pretend to act like malingerers, which might very well not be how malingerers act at all.*

Doctor, have you read *The role of Defense Neuropsychologists Should be* Limited Under Virginia Law, which is contained in the Journal of Virginia Trial Lawyers *Association*, Fall, 2002, p 24-32 which concludes that malingering studies are not scientifically reproducible and should not be utilized or even admissible as evidence because not only because of lack of science but also troubling ethical concerns because the doctor is essentially claiming to be a mind reader and knowing what is in the mind of the patient when the patient fails the test?

Often a malingering test will result in your client "flunking" when he or she gets most of the answers correct!

The Test of Memory Malingering, for example, puts your client in the malingering range if he or she gets 89% of the answers correct on three separate trials.

Does that sound fair?

What parent would stand for a teacher flunking his child when getting 89% of the answers correct?

Let's take a look at the scoring method. What does it take to pass this test? In terms of scoring? So if my client scored a ___ that is a passing score. If they got ONE question more incorrect, let's say someone opened a door nearby or they heard a sound and were distracted during these 2000 questions. THEN by one question they are committing insurance fraud?

What if the patient passes most of the malingering tests?

Doctor, even though my client passed malingering tests you kept on giving him more tests. You were hoping sooner or later he'd get sick of it and not try anymore so you could call him a malingerer, weren't you?

So my client decided "hey, I'll fake this test but not this other test" Does that really make sense?

So, my client passes most of the malingering tests and you focus on the minority and call him a malingerer?

Malingering and Depression:

Many malingering tests are actually tests of effort. If most people do well on a test and your client does not, that does not mean your client is intentionally doing poor.

Ask the doctor to admit that if someone has depression even the smallest tasks can seem overwhelming? See *Diagnostic and Statistical Manual,* TR, 4th edition American Psychiatric Association chapter on depression, page 350.

Doctor, isn't it true that none of the tests you gave for malingering rule out or even test for depression?

Doctor, isn't it true that you don't have any idea why the individual might have done poorly on a test?

Malingering and Frye/Daubert questions:

Doctor, can you please show me documentation that people with my client's mental AND physical condition were represented in the normative sample for this malingering test?

Doctor, please show me where this test was replicated and please identify how the questions were determined in the first place.

What is the sensitivity and specificity rate? (i.e. how accurate is the test at ruling out or in malingering? Remember, if it is 100% accurate at finding all malingerers keep in mind you can achieve those statistics by creating a test that calls you a malingerer if you breathe air. In other words, anyone who takes the test is called a malingerer therefore, if there are any malingerers who take the test it will always catch them all!)

Doctor, you have done no poll to determine WHICH malingering test most of your peers rely on, have you?

Therefore, you cannot say or show data that the significant relevant majority of your peers use THIS test you used, can you?

In fact, "There is no single benchmark test of malingering," is there? (see page 113 Non Neurological Factors in the Assessment of Head Injury. *Journal of Clinical and Experimental Neuropsychology*, 28:III-125, 2006)

Doctor Dishonesty/Bias:

Doctor, when you gave this test you told my client you were going to give her a memory test that may be difficult but she should do her best, right?

Doctor, you lied twice, didn't you?

The malingering test is NOT difficult. It's very easy and it's not a memory test at all, is it?

Doctor, have you ever told a lie? *(If he says yes, then say, Doctor, does that mean that we can't believe anything you have to say, since you are apparently saying this individual wasn't straightforward on one test, therefore, we must throw out all the data? And if he says no, say, Doctor, if he indicates he's never lied, say Doctor, can you*

agree that if you indicate that you've never told a lie on a similar question on the MMPI you get a point for being a sociopath because everyone lies!)

Doctor, isn't it true you can have brain injury regardless of the scores on malingering tests?

Doctor, you didn't even bother to ask my client why he apparently didn't try on this test, did you?

Doctor, you are essentially accusing my client of committing a felony which is insurance fraud, aren't you?
Now let's take a look at this.

As I understand malingering, you are saying that my client is not being honest because my client wants to get money essentially from this lawsuit, correct?

Now, Doctor, who would have more motivation to lie, an individual who was told to lie and then advised they would be given a dollar for lying and the dollar may or may not be paid in 30 years or an individual who is told to lie and then being told they would be given a fifty thousand dollars a year for the next ten years starting with tomorrow?

So the more direct, immediate, and constant the compensation the more the motivation to be dishonest, right?

Now Doctor, let's take a look at this. My client was injured almost 6 years ago. Trial is going to be years after the injury, *correct*?

Isn't it true that one never knows how the jury will rule? My client could lose?

Now let's take a look at your situation. You require pre-payment before you even see the person, don't you? So you always get paid when you are hired to conduct these evaluations, don't you? You make more on these evaluations then you do in your regular clinical practice, don't you? And, in fact, if you continue to get such referrals, you could, over life of your career, make millions of dollars, couldn't you? And Doctor, so that means that your compensation for your testimony is direct, immediate and constant, whereas the client's potential *compensation is not direct, is not immediate and absolutely not* guaranteed. Therefore, using your own example, you have more motivation to lie than my client, don't you?

Now, Doctor, there are lots of reasons for poor performance on effort tests. Those can include if a computer is used, computer anxiety, reading difficulties, problems with concentration, lack of focus, perseveration, irritability or even anger. That individual may not even want to be in the room with you and may not care because they are so apathetic, secondary to a brain injury as to what their answers are. Isn't that correct?

Now Doctor, did you bother to tell the patient that you were going to be testing them for honesty or that an effort in honesty would be required? *(If they say no, point out that Page 424 of the Symptom Validity Assessment Recommendations by the National Academy of Neuropsychology (Archives of the Clinical Neuropsychology (20) 2005 419-426) suggest that the doctor should say that and, therefore, this doctor is violating his or her own protocol.*

Now Doctor, have you read *Controversies in Neuropsychology* by Dorothy Sims in the Brain Injury Professional Magazine, Volume 2, Issue 1, the official publication of the North American Brain Injury Society discussing malingering tests? This article indicated one got points toward malingering when the individual was actually telling the *truth*, right? It fact, they would not get a point towards malingering if they *lied*, right?

That indicates that the doctor may have potential for bias that may even be greater than the patients, right?

The bias of the research indicating in that particular, for example, in the Lees Haley Fake Bad malingering scale, Dr. Paul Lees Haley has the practice that consists of so much defense referrals that he has a template already prepared before he sees a patient, indicating it was a defense referral. Therefore, perhaps, potentially affecting his own bias in reporting the data, wouldn't you agree?

Now Doctor, did you bother to tell the patient that you were going to be testing them for honesty or that an effort in honesty would be required? *(If they say no, point out that Page 424 of the Symptom Validity Assessment*

Recommendations by the National Academy of Neuropsychology (Archives of the Clinical Neuropsychology (20) 2005 419-426) suggest that the doctor should say in the beginning that they are going to test for full effort.

Malingering and brain injury:

Doctor, who are some of the most well respected authors on neuropsychological testing in this country (The doctor will eventually name Murial Lezak)

Doctor, isn't it true that Dr. Lezak actually indicates that malingering is rare in the head injury population? See Ten Myths of Head Injury Recovery, http://www.getrealresults.com/tenmyths.html

Malingering and Pain:

Isn't it true that chronic pain can affect concentration? *(If he denies ask him whether pain might interfere with these malingering tests if he gave them to his wife while she was in labor, assuming she lets him live after he asks her to take the test.*

Doctor, you claim malingering tests were given to pain patients and they passed. How do you know they were in the same amount of pain as my client?

Did you ASK my client if he was in pain?

Was he on narcotics that can affect his level of concentration and effort?

MALINGERING IN GENERAL

Doctor, is it your testimony that malingering can be suspected to exist solely because an individual is a party in a law suit?

Doctor, were YOU ever a party to a law suit?

1. No malingering tests rule out ANY medical/psychiatric or neuorpsychiatric condition. Brain injury, PTSD, Depression or any other condition.

2. You can malingering and still have the condition,

3. Even if you are correct, if you are found to be a malinger based on any test that does not give you the ability to determine what % of what the plaintiff says in the future, say at trial, is malingered or not.

4. Malingering tests are usually nothing more than effort and no-one, NOONE knows why your client may have given poor effort, if in fact, he or she really did.

5. Malingering implies intent and the doctor has no idea as to the patient's intent and I have never, ever had a doctor bother to ask the patient.

Example of a "malingering" test.

Word Memory Test: This test was created by Dr. Paul Green, PhD who receives significant defense referrals.

> Traumatic Brain injury patients have elevations in scale 8 on MMPI because that's where the concentration questions are loaded.
>
> Now schizophrenics have memory and concentration problems/
>
> A recent study showed that schizophrenics flunked the word memory test when they had no motivation to malinger. Over 50% flunked.
>
> Effort and Cognition in Schizophrenia Patients, *Schizophrenia Research*, 78 (2005 l99-208) Gorissen, Sanz and

Schmand.

Also 25% of the other psychiatric patients were found in malingering range in this test even though they also had absolutely no external reason to malinger.

Doctor, have you considered how much money these doctors make SELLING their tests?

What percentage of these doctors who claim they can call someone a malingerer actually have almost 100% of their income from the defense OR sell their tests and scoring methods to doctors who do almost all defense (considering the defense profits from a finding of malingering)

Ethics of administration of malingering:
NAN ethics

Indicate if you flunk a malingering score in personality inventory you can't draw same conclusion from TBI and visa versa, right? Yet that's just what you did, isn't it?

It also says if you give a malingering test and it is close to a passing score you can't automatically conclude malingering even if they flunk, right?

If doctor relies on tests that were not created as malingering scales (pain scales, or claiming testing patterns or answers in other tests that are not malingering tests themselves are indicative of malingering)

Doctor, does this test have a manual teaching doctors how to administer and score the test?

If it does not, (i.e. pain scales). WHAT? Then you can claim this test means anything, can't you?

There is no manual anywhere letting you use this test in this manner, right?

Doctor, show me the pain questions and my client's answers

(Pick some out as a representative sample that your client SHOULD endorse. Point out that this then gives him a point closer to malingering scores when he or she is telling the truth. If the doctor refuses to answer claming test security point out the pain scales have no publisher to object and these scales are available in public peer review articles.)

So, let's see, if my client endorses or answers questions in these here pain scales that s/he is in pain, or it is significant or throbbing etc, then they get points towards malingering. If they don't endorse them then you get to say there's nothing wrong with them!

If plaintiff from another country/culture:

Doctor, my client was not originally from this country, was she? She came from a different culture, didn't she?

Doctor, isn't it true that before you can render an opinion on malingering you have to evaluate her cultural background to determine any cultural factors that could result in conclusions?

You didn't do that in this case, did you?

You didn't ask her ANYTHING about the differences between her prior culture and this one.

Did you, "Note the individual's ethnic or cultural reference groups" per below?

Then reference back of DSM entitled culture bound syndromes page 897, APA DSM TR. published by the American Psychiatric Association.

Please note that certain cultures may fail certain malingering tests at a greater rate than others based not on actual malingering but cultural issues.

Make sure your client's culture was adequately represented in the normative sample.

BOARDWALK 2005

Biased? Call it 'malingering'

By Dorothy Sims

My practice is limited to the direct and cross-examination of doctors hired by the defense. I have a great many cases involving psychiatric or neuropsychiatric issues and repeatedly hear comments like:

"Your client is exaggerating."

"This test confirms your client is malingering."

"Your client failed to give full effort and we must be suspicious of anything he or she says."

I decided to do some research because, frankly, I could not imagine I just happened to have been affiliated on cases, *all* my cases, in which the plaintiff is a bold-faced liar.

Often a defense expert will testify my client is malingering a brain injury and, by the way, no one *really* gets injured in mild TBI anyway. Furthermore, the plaintiff has a normal MRI and CT scans. (Remember, a CT scan or MRI, unlike a PET scan, is a picture of the brain. These tests do not show function. You can be dead and have a normal CT scan or MRI.)

Oppenheimer's study as far back as 1975 reveals 75 percent of the brains of mild TBI victims evaluated by autopsy (when the patient died of other causes) had "microscopic lesions characterized by capillary hemorrhages and severing of nerve fibers without hemorrhage."

More recently, an autopsy performed on a 47-year-old man who died — from causes not related to a mild TBI seven months earlier — revealed trauma findings of hemosiderin-laden macrophages in the perivascular space and macrophages in the white matter.

How about the study involving mice evaluated by a T7 MRI, wherein even when the imaging studies were normal, after a mild brain injury, the mice showed "profound learning and memory deficits."

I'm just waiting to ask the defense doctors if those wily mice were just a bunch of malingerers.

Let's look at one of those "malingering" scales. The Lees-Haley Fake Bad Scale was created by neuropsychologist Paul Lees-Haley. In a recent deposition of the doctor, Lees-Haley advised that his practice is "almost all defense." His practice is so reliant on defense referrals that his template, or pre-written report, already indicates the *defense* hired him before he even receives the referral.

He treats no patients.

By the time the case in question comes to trial, his charges could exceed $25,000.

Is it possible, just possible, there could be a built-in bias in favor of finding *no* brain injury, considering the publications one produces and the source from which one's income is derived?

I ask, instead, how many mild brain injury patients are *falsely* accused of malingering or even of having no brain injury?

How does this Fake Bad Scale — used to claim our clients are lying or exaggerating — actually work?

Let's say a patient has a car accident, hits his head and herniates a disc in his neck. He can no longer work and becomes depressed and anxious. He is on narcotics for pain, and the pain interferes with his sleep. This is not an uncommon scenario.

The following is an example of why this "malingering" scale might not be appropriate and could explain why Dr. James Butcher, the individual who co-normed the MMPI2, as well as Pearson Assessments, remains so opposed to the use of the Lees-Haley Fake Bad Scale on the MMPI2.

The Lees-Haley scale gives this man a point toward malingering for each statement even when the patient is telling the truth.

- Feeling pain in his neck
- Experiencing headaches
- Having a great deal of stomach trouble (common, by the way, when taking narcotics and/or if suffering from anxiety)
- Sleep disturbance
- Having difficulty keeping his mind on-task
- Feeling like he is about to go to pieces
- Having more trouble than others concentrating
- Feeling pressure or stress
- Feeling tired most of the time
- Feeling his difficulties are piling up so much that they cannot be overcome
- Having an unsatisfactory sex life
- Being so sick of what he must do every day he just wants out of it all
- Considering killing himself
- Tiring quickly
- Everything seems to taste the same (anosmia)
- Having fitful and disturbed sleep (pain/depression certainly can cause this)
- Nausea and vomiting (back to side effects of narcotics)
- Having pains
- Having nightmares every few nights (anxiety), and
- The man wears glasses? He even gets a point toward malingering if his eyesight has deteriorated over time

We are now up to 21 points toward malingering when each and every complaint can be clearly and honestly explained by this man's condition.

Now, keep in mind that a man only needs a score of 24 to be considered a malingerer.

Pretty easy to do if you're hurt, depressed and have a brain injury. In fact, one could conclude that failing the Lees-Haley Fake Bad Scale is *proof* of a brain injury rather than malingering.

An example of the problem with this "malingering" test is seen in Dr. Lees-Haley's deposition testimony in *Trotter, et al. v. Washington International, et al.*:

A: *If she is feeling pain in the back of her neck and answers truthfully then that item would be wrong for her.*

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Q: She would get a point for malingering, according to your scale, even when she's telling the truth. Is that or is that not, Dr. Lees-Haley, correct?
A: If she's feeling pain truthfully and answers the question truthfully, yes.

Why do defense doctors seem to disagree with those neuropsychologists who dare to start out believing their patients rather than assuming the patients are lying monsters created by greedy lawyers?

These "malingering" tests are not the panacea he and others would have you believe. Recently, a defense doctor opined malingering in a case based on the Word Memory Test. The plaintiff's attorney took and failed the test. The patient's own psychologist took the test. *He* failed. This gives one pause.

Even getting the tests themselves may be a problem. Often the neuropsychologist will refuse to release the test results to the attorney to review. Trust me. You need this information. Recently, in an article written by Dr. Lees-Haley in *Claims* magazine, a publication relied upon by the insurance industry, he states:

> "Psychologists who claim that the ethical code of psychologists prohibits disclosure of tests and raw test data to attorneys, judges and jurors are misinformed. ... Competent psychologists know from the outset that their work will be scrutinized in the context of trial proceedings."

He goes on, "For example, if a psychologist claims an attorney is not qualified to use the data, one must ask, 'Who is better qualified than an attorney to use the data to cross-examine a psychologist?' "

It appears, however, that Lees-Haley is only upset that, apparently, the *defense* attorney is having difficulty getting the data: "And if psychologists can give the data to a patient or client, who is a plaintiff, then in effect they are giving it to the plaintiff attorney, but not the defense attorney. So, how can they claim to be unbiased?"

It's time to admit the emperor has no clothes. There is a potential for bias on the part of doctors who evaluate individuals solely for the defense. A bias that seeks to find malingering regardless of the facts. I'm just a simple lawyer. I have had *no* formal education in mental health. However, since I now devote my practice solely to cross-examining doctors hired by insurance companies, I see things I just don't understand.

Doctors who are retained by the defense and cannot think of a single case in the last 15 years or so where they have testified that the patient was telling the truth, will opine deception/malingering based, in part, on:

1. Changing cut off scores so they can opine malingering.
2. Claiming someone is "borderline flunking" malingering scores.
3. Giving a brain-injured patient repeated malingering tests; more, in fact, than the tests used to actually determine brain injury. Then, when the patient passes 90 percent of them, conclude malingering; or
4. Same scenario as number three, but after the plaintiff passes all standardized malingering tests, malingering is concluded because the patient endorsed pain symptoms.
5. Instructing patient to erase an answer.
6. Giving a computerized malingering test, then when all raw data is required to be released, "forgetting" to release the computer printout that indicates the patient is answering in an honest and straightforward manner.
7. Claiming an MMPI, with all validity scales well below T65, means malingering because the depression scale was elevated or superimposing some controversial scale upon the MMPI to ultimately claim "malingering."
8. Giving a brain-injured patient a "malingering" test he is not able to read and then when he performs badly (still better than chance), labeling him a malingerer.
9. Giving a Hispanic plaintiff who arrives with an interpreter a malingering test in English.
10. When a patient appears to be doing very poorly on a test for brain injury simply not scoring the results.
11. If the patient is passing a malingering test, not calling the test a "malingering" or "response bias" test. Just report the numbers and refuse to release that particular portion of the raw data when requested by plaintiff's attorney.
12. Giving the plaintiff the California Verbal Learning Test. After poor performance on the forced choice section, concluding they are malingering. If they do well concluding they don't have a brain injury because they did so well. Even better — leaving the whole forced choice issue out of the report altogether.

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Biased or malingering?

CONTINUED FROM PAGE A5

Now, usually these individuals never have to explain their behavior. Why? Because most attorneys don't know raw data can no longer be hidden pursuant to new HIPAA laws and even if they got the data, they wouldn't understand it.

Ok. Now what? What about "research" that supports certain answers lead one to conclude malingering or, for that matter, the "fact" that most mild brain-injured patients are just plain fine?

Perhaps researcher bias should be considered. Bias in publications has long been a serious problem (over-reporting and/or withholding responses). In fact, recent research reveals concealment occurs in data reporting in a majority of the cases.

An observational study found that authors of randomized controlled trials frequently use concealment of randomization and blinding, despite the failure to report these methods.

Where in the articles on malingering is it revealed if the author receives the significant bulk of his or her income from the defense who serves to benefit from the article?

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So, if one describes malingering as an individual modifying his or her behavior for external gain, does not the potential for that very problem exist with the doctor him/herself?

When cross-examining various neuropsychologists retained by the defense and I began to inquire about issues such as these I have been threatened with arrest in the middle of deposition; advised I was an "unethical shyster and trickster" and accused of manufacturing evidence; and told I should obtain a concealed-weapon permit and attend the depositions armed.

Why? Could it be this type of behavior is based on the territorial protection of a feeding source? There is much more money in forensic neuropsychology than for the poor practitioner out there in the field, arguing with insurance companies who mark down his or her bills or downright refuse to reimburse for treatment and whose treatment for years may be 1/10th the bill for a single evaluation by a "forensic" neuropsychologist as a result of one of those accidents "of no consequence."

My heart goes out to those fine people and their poor patients . . .

LAD players, procedures

CONTINUED FROM PAGE A18

(Law Div. 1998), holding the employer could not compel a current employee to sign an arbitration agreement. In order for an employment agreement to effect a proper waiver, however, it must "clearly and unmistakably" waive the employee's statutory rights. While *Galarza* indicated that broad language compelling arbitration of "any dispute" between the employer and employee could effect a binding waiver, the court suggested such language should be more specific. This includes noting federal and state administrative and judicial remedies exist, that by signing the contract these remedies are forever precluded and that regardless of the nature of the complaint, it can be resolved by arbitration.

The state Supreme Court in *Garfinkle v. Morristown Obstetrics & Gynecology Inc.*, 168 N.J. 124 (2001), held a plaintiff may waive the choice of forum to raise LAD claims only if the intention is clearly established. Although the employment contract need not refer specifically to LAD or list every imaginable statute by name to effectuate a knowing and voluntary waiver of rights, it must reflect a general understanding of the type of claim included in the waiver.

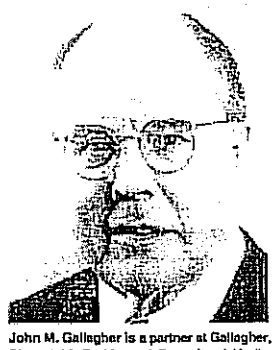
Exhaustion

The defense of exhaustion can arise in several contexts. For example, in the employee handbook case of *Fregara v. Jet Aviation Business Jets*, 764 F. Supp. 940 (DNJ 1991), the court ruled that where an employer's handbook creates a grievance procedure, the employee must first exhaust the procedure before suing on the handbook. In the collective-bargaining context, the case of *Thompson v. Joseph Corey Warehouses, Inc.*, 215 N.J. Super. 217, 220 (App. Div. 1987), discusses exhaustion of a collective bargaining agreement's grievance procedure and also outlines circumstances under which the court may not require a plaintiff to exhaust his or her non-judicial remedies. ——•

Jury hate you?

CONTINUED FROM PAGE A6

25 Confront opposing witnesses with documents without showing the documents either to opposing counsel or the witness. This technique was employed skillfully by Senator Joe McCarthy.



John M. Gallagher is a partner at Gallagher, Shoenfeld, Burkin and Chupein of Media, Pa. He practices medical malpractice, dangerous products and personal injury litigation, and is president of the Pennsylvania Trial Lawyers Association.

26 Deliver your summation with raging passion, pounding mightily on the jury-box for emphasis and screaming at the jury while showering them with your own spittle. This, after all, is the theatrics of the *Grand-Guignol* they have been waiting for!

27 Object repeatedly during your opponent's closing, just to throw him or her off pace, even after the judge tells you to stop objecting and sit down.

28 During the judge's instructions to the jury, listen in rapt attention to any instruction with which you agree. Shake your head and look amazed during any instruction with which you disagree.

29 When the defendant's verdict is rendered, glare at the jury, hurl your pencil at the bench and march out of the courtroom with your head held high.

After all, you did your best! ——•

Defense ✔ list

CONTINUED FROM PAGE A17

Inappropriate syndromes

As early as 1989, Dr. Gary Melton and Susan Limber in "Psychologis Involvement in Cases of Child Maltreatment" [*American Psychologist* Vol. 44, No pp. 1225-1233] commented on the inappropriate use by therapists of syndromes n found in various versions of *Diagnosis and Statistical Manual*. There has been a pr liferation of these over the last several years. Using syndromes not appropriat researched or acknowledged by the profession is below standard of care. Among thc which are controversial and which should not be represented as accepted in the th apist community are Child Sexual Abuse Accommodation Syndrome, Paren Alienation Syndrome, [*Wiederholt v. Fischer* 169 WIS 2d 524, 45 N.W. 2d 442 (1992 False Memory Syndrome and Malicious Mother Syndrome.

Out-of-office contact

As a general rule, unless there is a specific therapeutic purpose for it, patie should only be seen in the therapist's office. Instances of seeing a patient outside office should be extremely rare and well-documented in the patient file. If an out-office contact is going to occur, the therapist should document in advance its purp and goals. Afterwards, the therapist should document what actually occurred, a whether and how the perceived goals were met. It would be sound practice to obt a peer consultation before an out-of-office session (other than phone contact).

No peer consultation

One of the most common failings is not having a regular peer consultant or c sultation group from which to obtain feedback. The progressive isolation of therap due to economic factors has created the potential for erosion of clinical judgm Peer consultation can be the quickest way to avoid a pitfall. Of course, if a thera obtains a peer consultation and acts opposite those recommendations, there ca potentially serious consequences. Whenever consultations are obtained should course, be well documented as experts frequently determine whether a therapist c plied with standard of care by determining whether peer consultations were purs and heeded. ——•

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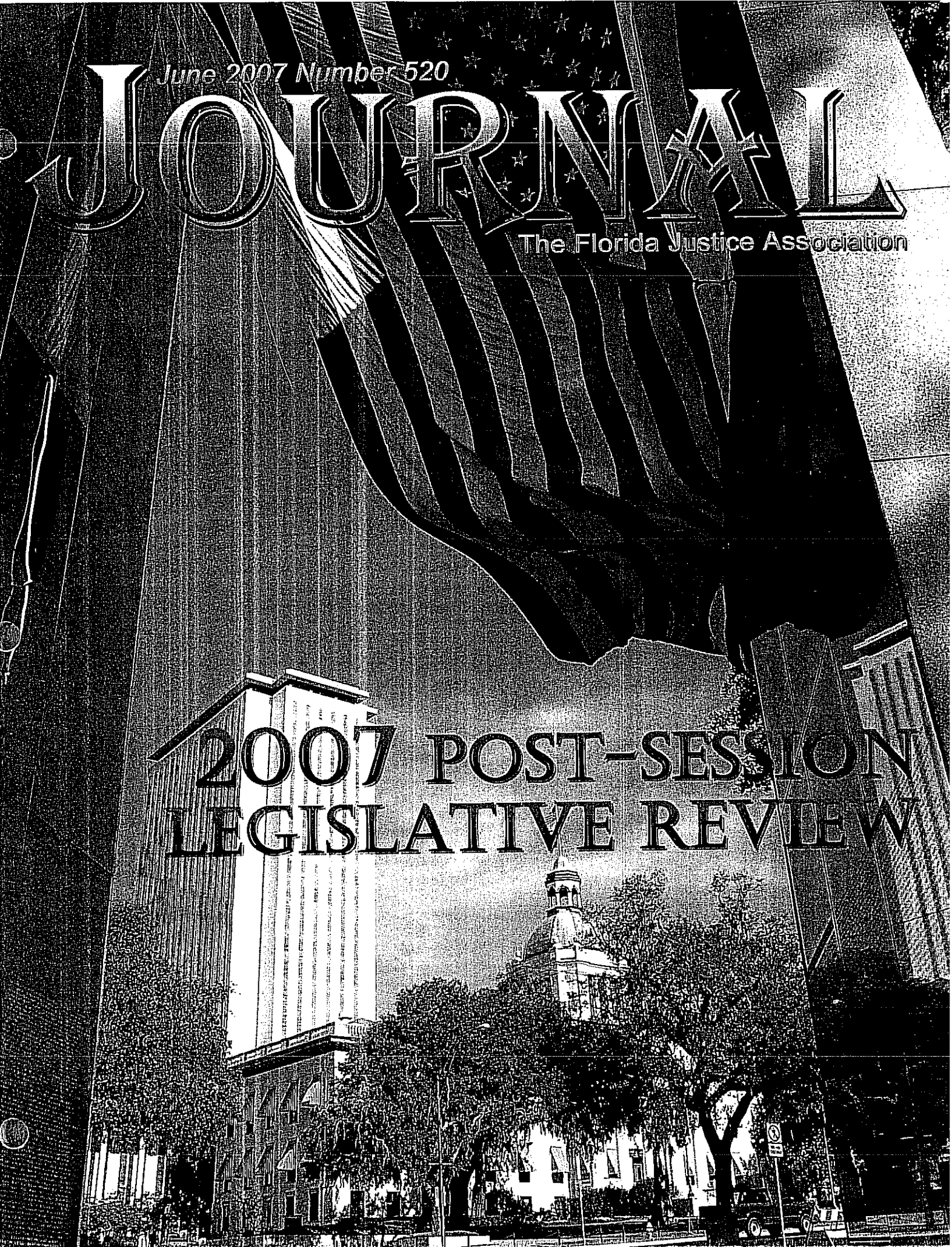

2007 POST-SESSION LEGISLATIVE REVIEW

Guest Column

Dorothy Clay Sims
Sims, Amat, Stakenborg & Henry, P.A.

The Myth of *Malingering* Diagnosing Dishonesty in the Courtroom

Science or sophistry?

On December 9, 2002, fifty-year-old Hildegard Trotter sustained brain damage when she was broadsided by a semi-tractor trailer. The defendant's insurance company hired a doctor who claimed to perform "*scientific*" tests that resulted in charges of malingering. Hundreds of hours of research proved that indeed dishonesty was an issue.

The doctor admitted that *he* may have lied to *her* and that one of the tests that he relied upon to determine malingering actually could have reflected answers on her part that were completely truthful. [1]

This is an example of abuse of psychology and psychiatry that gets played out in cases involving personal injury, child custody, divorce, criminal charges and insanity issues throughout the United States.

A claim of malingering is tantamount to accusing the plaintiff of committing insurance fraud, and it should be taken seriously. Motions in Limine based on scientific reproducibility standards should be considered.

Doctors who receive significant monies from legal work are, with increasing frequency, rendering opinions that individuals are *malingering* based on tests of dubious scientific validity. People are being diagnosed as liars, sociopaths, denied custody and even visitations of their children. They are denied Medicare, Medicaid, long-term disability benefits, workers' compensation, or health insurance benefits based upon tests with little to no basis in science. It is the job of the judge or jury and *not* the doctor to decide truthfulness of a witness.[2]

A claim of malingering is tantamount to accusing the plaintiff of committing insurance fraud and it should result in a Motion in Limine.

Malingering tests typically involve four basic types.

Effort Tests

The theory behind some of these tests is that if an individual scores too low on an easy test then the presumption is that the individual knew the correct answer and intentionally answered incorrectly. Therefore, the doctor concludes malingering because the patient attempted to make himself or herself appear more impaired than facts would support.

Examples: Test of Memory Malingering, Rey's 15 Item test, Word Memory Test.

Pain Scales

These tests ask the patient to rate the frequency and type of pain. Some tests may question how the pain affects the patient's life. If the patient endorses enough items the conclusion is that he or she is malingering. How can a patient with serious physical problems ever not have an elevated score and also *not* be malingering?

Example: Pain Disability Index, Modified Somatic Pain Questionnaire

Psychological Symptom Endorsement:

These tests ask the patient to endorse various psychological or perceived psychological symptoms. If too many symptoms, i.e. feeling sad, hearing voices, crying frequently, then the assumption is that the plaintiff is exaggerating symptoms because individuals with true psychiatric symptoms do not endorse the same ones or, perhaps, as many.

Example: MMPI2, Personality Assessment Inventory, MCMI

Discussion

Malingering tests are fraught with problems. What is the basic science behind them in the first place? Is the normative sample reliable and scientific? Who really knows how a malingerer will answer a particular test in the first place? Many of the samples upon which these tests are based contained college students told to *pretend* answer the questions as though they *believe* a malingerer would answer them. Studies indicate that college students pretending to malinger are not, in fact, being how true malingerers mayapproach the test.[3] How, then, is a test of this nature able to predict behavior of a group of individuals to whom it was never applied? No one knows how a true malingerer would approach the test.

That would be similar to concluding that studies showing 900 milligrams of Gabapentin help alleviate seizures in the adult normative sample and, therefore, the same dose should apply to infants.

In fact, this unreliable testimony, if allowed, would create a false appearance of scientific reliability and accuracy that would be extremely likely to improperly influence the jury.[4]

Someone with genuine organic brain damage or depression may have difficulty staying on task and may end up frustrated and simply randomly responding. Often the test battery may take two full days to complete and at the end of the day, the patient may be fed up, not intentionally doing poorly for secondary gain. The doctor himself may intentionally interfere with the patient as he or she is answering these tests then claim scientific proof of malingering.

Malingering tests may reflect poor effort, a clear symptom of depression. For someone who is depressed, "even the smallest tasks seem to require substantial effort. The efficiency with which tasks are accomplished may be reduced."[5]

Poor scores can also reflect anger. The Portland Digit Recognition Test, in and of itself, can be so irritating and insulting to the patient that the patient may get angry and not continue putting effort in the test.[6] Patients who performed at their best on all other tests report becoming sufficiently annoyed, either because it is a protractedly boring test to take or they feel that it

insults their intelligence such that after a while they give answer without attending to task.[7]

Poor scores may actually reflect psychopathology. Poor scores on the Rey's 15 item test may actually be able to show brain damage rather than malingering, especially if the individual is older.[8] Another problem with this *malingering* test is that when analyzing the accuracy rate of the test, 27 percent of patients scored in malingering range wherein only 15 percent were told to fake.[9] That means that this test is not much more than 50 percent accurate, perhaps the same as *flipping a coin.*

Poor scores can reflect noncompliance. *Noncompliance* is actually a sign of brain damage.[10] The unscrupulous doctor could claim no brain damage because the patient was so compliant or, if the patient was not compliant, the patient was malingering.

Some malingering tests also require impossibly high scores to avoid the malingering label. The Test of Memory Malingering concludes malingering unless the plaintiff passes at least 90 percent of the questions.[11] What parent would stand for a teacher flunking his or her child on a test wherein the child received an 89 percent?

When these tests were created and the normative basis created to which your client is compared, they were not given to the individual while also giving some 16 hours of neuropsychological testing. Days of testing can be exhausting, especially to the patient on narcotics, in pain, suffering from brain damage, or psychiatric conditions. That being the case, no malingering test should ever apply to your client, because your client wasn't represented in the normative sample. Furthermore, no malingering test was normed on individuals who were forced to go to a CME not trusting the doctor and not wanting to be there in the first place. Therefore, again, no malingering test should apply to your client.

If the normative sample must contain individuals like your client, then how many people in the normative sample were on pain medications, or had the same level of pain and physical problems as your client?

Other functional problems that can account for poor scores include whether the test required typing. Did the plaintiff have visual problems? Problems typing due to carpel tunnel syndrome? Problems sitting? Was the plaintiff old? Being elderly can affect tests and cause computer anxiety.

Was the test given in the patient's native language? In fact, can the patient even read?

If patients have brain damage and are given tests of concentration, they may perform poorly because concentration is difficult. They are then branded a malingerer. If they *pass* the test, doctors may conclude that means no concentration problems and, therefore, no brain damage. Either way they lose.

No one knows exactly *why* a person may score poorly. Even when test scores lead to virtual certainty that a person's self report is unreliable, that alone says nothing about a person's motivation for giving an unreliable account.[12]

Rarely, if ever, would the psychologist consider the obvious. *Ask* the patient why he or she scored poorly. "Doctor, did you even bother to ASK the plaintiff why he did poorly?"

Perhaps the most egregious abuse occurs when the doctor himself lies to the patient when giving the test, calling the test difficult when it is very easy, or calling it a memory test when it is not.[13]

ISSUES IN BIAS

A discussion of psychological tests must also include potential bias of research or test itself. While there are studies published in psychological journals that support the use of malingering tests, nowhere is the bias of the researcher discussed. The bias of the investigator may play a part in the creation of the test itself (does he or she receive his or her entire income from sources tending to benefit in claims of malingering?) Often a researcher may not disclose financial ties. For example, recent research reveals that in over 95% of the cases, drug research papers do not reflect the author's economic ties to the industry. [14]

Some malingering tests are such that the plaintiff simply cannot win. Example: The Lees Haley Fake Bad scale which is being applied towards certain answers on the MMPI2. This scale contains a question wherein if the patient answers false he get points towards being a malingerer on this scale but if he answers true he gets a points towards exaggerating on the F scale (another malingering scale) of the MMPI2 to which it is applied. No matter how he answers he gets a point towards being dishonest. Furthermore, consider the author of this Fake Bad Scale—a psychologist who receives the bulk of his referrals from the *defense*, created this *test* to see if individuals are malingering, PTSD, brain injury/ depression but then pulled questions one would expect individuals with this condition to endorse (i.e. poor sleep, headaches, trouble concentrating) and then when those symptoms are endorsed, concludes malingering. This is very helpful to the defense because if the patient does not endorse the symptoms, there is nothing wrong with him. If he does, he's malingering.[15]

What if the doctor manipulates the test results? Sometimes the doctor is the one who misleads the patient by the way the test is administered. When malingering tests are given to the patient, the patient is not told he or she is being tricked. The doctor can make testing conditions difficult and, in one case, a plaintiff went back to retrieve her purse and found the doctor actually erasing her answers.

Is there even a need for these tests? They cannot predict a future act or even rule out the underlying condition, i.e. brain injury, incompetence, insanity, depression, etc. They tell us nothing of the probability of lack of candor in other areas (i.e. the patient scored 85 percent on a malingering test therefore we can only believe 85 percent of what she says). The conclusion that an individual is, overall, not trustworthy or believable because of one test or event is unscientific. Assuming one relies on these tests, does that mean if the doctor ever misrepresented something (No, dear, that dress does *not* make you look fat) at any time then one must then never believe anything he or she says from that point?

Just what exact answer or symptom led to the conclusion that the patient malingered in the first place? Most doctors have no clue. Even if someone fails a malingering test, this can't be construed to mean they don't also have the underlying condition as well (i.e. PTSD, depression, brain injury, etc.) The most a doctor can conclude is that *his own data* is unreliable. To make the quantum leap that the doctor knows the plaintiff:

A. Knows the correct answer,
B. Is intentionally answering incorrectly, and
C. Is doing so for money from a law suit is not supported by any science whatsoever.

I have yet to have a case in any of the depositions of doctors whom I've deposed (and my practice is limited to cross examining doctors for other lawyers) wherein a doctor has ever bothered to ask the patient *why* he or she answered the questions the way he or she did. No. It's much more beneficial to the party who retains the doctor to have the doctor leap, in the absence of science and/or adequate information, to the conclusion of "malingering."

Many courts reject the ability of one witness to comment on the credibility of another.[16] That is simply the job of the jury. Malingering tests are nothing more than doctors claiming science backs their ability to call the plaintiff a liar. Why not demand such a test be given to the defense doctor?

Secondary gain involves a lack of honesty for financial gain. The rewards must be direct and immediate and constant. Who ALWAYS gets paid, often up front but certainly directly and immediately? That's right. Not the plaintiff who may wait years for a lawsuit and have no idea what the jury will do and only has one shot at this. The defense doctor, however, gets paid with each referral, receives future business and always always gets paid, regardless of outcome and can even get future referrals. "So, doctor, if we apply the same standards to you, then *you* actually have more motivation to be dishonest than the plaintiff, correct?"

Conclusion:

A doctor who claims to be able to know why an individual did poorly on a test without scientific data to support the conclusion should be stricken as an expert. Unfortunately, oftentimes the defense will retain an expert for the sole purpose of branding the plaintiff a liar when, in fact, the doctor hired by the defense has *more* motivation to misrepresent facts. The plaintiff's lawyer is urged to deconstruct and demystify the alleged science behind test.

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[1] *Trotter, et al. v. Washington Group International et al.*, case O:A 466736, Dept No: v 111 (D.C. clerk co. v 2004). August 19, 2004, deposition of Dr. P.L.H, pp. 94.

[2] *State of South Dakota v. Raymond*, 540 N.W.2d 407, 409 (S.Ct. SD 1995).

[3] Faust, David & Margaret A. Ackley, *Did you Think It Was Going To Be Easy? Some Methodological Suggestions for the Investigation and Development of Malingering Detection Techniques, in Detection of Malingering During Head Injury Litigation.* Reynolds ed., Pub. Plenum Press, NY: 1998: pp. 28.

[4] Creager, Shea, and Larner. *Emerging Issues, Role of Defense Neuropsychologists Should Be Limited under Virginia Evidence Law.* The Journal of the Virginia Trial Lawyers Association. Fall 2002: pp. 27.

[5] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders Text Revision, DSM-IV-TR. 2000, 4th ed., Washington, D.C., pp: 350

[6] Lezak, Howieson, Loring, Neuropsychological *Assessment* at 773 (2004), 4th ed Oxford

[7] Lezak, Howieson, Loring, Neuropsychological *Assessment* at 773 (2004), 4th ed Oxford.

[8] Spreen and Strauss, *A Compendium of Neuropsychological Tests, Administration, Norms, and Commentary* at 674 (1998), 2d. ed. New York Oxford.

[9] Spreen and Strauss, *supra* at 672.

[10] *"Hope Through Research, Traumatic Brain Injury, National Institute of Neurological Disorders and Stroke"*/ National Institute of Health: pp. 22 http://www.ninds.nih.gov/disorders/tbi/detail_tbi.htm

[11] Lezak, *supra* at 774.

[12] DeClue, *Practitioner's Corner, Feigning is not equal to Malingering: A Case Study, Behavioral Sciences and the Law*, 2002: 20: pp. 717, 724

[13] Deposition of Dr. Paul Lees-Haley, M.D., *Trotter v. Washington Group International, Inc., et al.*, Case No. A466763 in the District Court of Clark County, Nevada, August 19, 2004.

[14] *Under the Influence*, Wired Magazine, May 11, 2003, Issue 11.05: pp. 59

[15] Deposition of Dr. Paul Lees-Haley, M.D., *Trotter v. Washington Group International, Inc., et al.*, Case No. A466763 in the District Court of Clark County, Nevada, August 19, 2004.

[16] *Lenz v. Commonwealth*, 261 Va. 451, 469, 544 S.E.2d 299, 301 (Va. 2001); *Kimberlin v. PM Transport, Inc.*, 264 Va. 261, 266, 563 S.E.2d 665, 667 (Va. 2002); *Feller v. State*, 637 So.2d 911 (Fla. 1994); *See also, Mills v. Redwing Carriers, Inc.*, 127 So.2d 453 (Fla. 2d DCA 1961).

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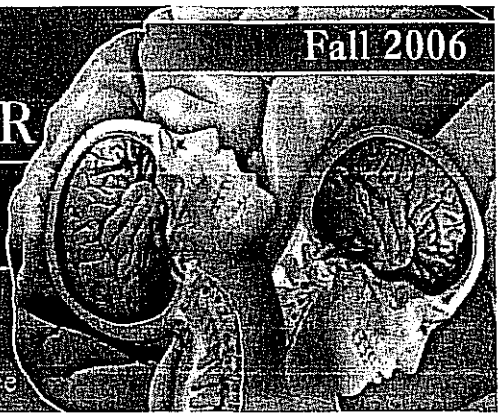
TRAUMATIC BRAIN INJURY LITIGATION GROUP NEWSLETTER

Fall 2006



AMERICAN ASSOCIATION for JUSTICE

A Publication of the American Association for Justice

nonpharmacologic treatments for PTH, it is possible that negative results were not published.

CONCLUSION

Most headaches are multifactorial and involve a combination of central and peripheral mechanisms. Therefore, clinicians should be careful in classifying PTH before administration of therapy. Unfortunately, there is a shortage of published articles on headache interventions specific to patients with PTH. In the interim, guidelines for treatment have been extrapolated from the primary headache medical literature. A tentative diagnostic and therapeutic flowchart is proposed by the current authors (consisting of three PM&R physicians, two neurologists, and one anesthesiologist) and illustrated in Figure 2. Finally, psychologic evaluation and behavior therapy, as well as lifestyle change and avoidance of medication overuse, are also important in the management of PTH.

Articles

THE PATIENT IS MALINGERING

By Dorothy Sims

Oooooh, don't get me started on this one. I hate these guys who claim "science" supports the conclusion that your client is a bold faced liar.

The most official definition of malingering is essentially someone who meets two out of four criteria:

1. They are involved in a law suit.
2. Their claimed level of disability is different than one would expect based on objective findings.
3. The plaintiff wasn't cooperative during the exam; and/or
4. The plaintiff has anti social personality disorder.[1]

Often the doctor retained by the defense will claim the plaintiff's condition exceeds what one would expect for the physical findings.

However, in most cases this requires the defense doctor to completely ignore the majority of the evidence, starting with the treating physician. The defense witness will rely only on other defense experts to claim the plaintiff doesn't have a real physical condition.

There is a name for this: it's called "confirmatory bias," (well, actually I call it bullshit) which exists when an individual ignores all data and information that is contrary to the conclusion he or she wishes to reach.

For someone to modify their behavior (i.e. act in a certain way to get desired results) that modification is most successful if there are rewards that are direct, immediate and constant. Now think about this:

Your client is injured in 2000. It may take 5 years to get to trial Even then, the jury may not find for your client.
So, the benefits are not:

-Direct
-Immediate
-Constant.

Wait!
Doesn't the defense doctor get paid right after, or even BEFORE the evaluation?
I.e. reward is:

-Direct
-Immediate.

Hasn't the defense doctor gotten paid in ALL cases and doesn't he or she make millions over the years from the defense? Thus, the rewards are direct, immediate and constant! So, the one who has the most motivation to modify their behavior (i.e. Lie) is THE DOCTOR.

"By the way, doctor, did anyone administer a test to *you* to see if *you* were being honest?

You can also go down another road guaranteed to get a chuckle.
Here's an actual deposition:

Q: Doctor, have YOU ever lied?
Pause
A: No. Not since I was a child.
Q: How old are you?
A: 59
Q: So you are saying you have NEVER told a lie in 41 years, never fudged a bit if your wife asks, "Does this dress make me look fat?"
A: Correct
Q: Doctor, are you aware that if you answer a question on the MMPI2 indicating you have never told a lie you get a point towards being a sociopath because EVERYBODY LIES?
Pause
A. Yes.

Or

Ok. What if the doctor admits to telling a lie?

Q: Doctor, you've taken no test yourself in this case to tell us if YOU are honest, right? And just because you lied in the past, you would not suggest that we cannot count on anything you have to say here today, right?

[1] Am. Psychiatric Ass'n., *Diagnostic and Statistical Manual of Mental Disorders*, 739 (4th ed. 1994)

A: Correct

Q: So even if the plaintiff DID lie in the past, it doesn't mean we should reject what she has to say here today either, right?

Why administer malingering tests?

Psychologists have been attacked for testifying based upon data provided by the patient. How does one know the patient was honest? What if they were only pretending to be depressed? How do you know if the patient is exaggerating?

These questions discount the doctor's own ability to tease out information independent of the tests to draw questions on credibility.

In response to these attacks, various malingering tests were developed. Other tests may be used as malingering tests that were not created as such.

Tests used to support claiming malingering include:

Word Memory Test
Test of Memory Malingering
Rey's 15 item test
Portland Digit Recognition Test
Application of Lees-Haley Fake Bad scale to MMPI2
Structured Interviews

Other tests used to claim malingering which were not intended for this purpose include:

Forced choice component of the California Verbal Learning test.
Wisconsin Card Sorting Test
MMPI2 (certain scales)
Millon Clinical Inventory (certain scales)
Personality Assessment Inventory (certain scales)

Pain scales that rate the type of pain or effect of pain such as:

McGill Pain Scale
Modified Somatic Pain Questionnaire
Pain Disability Index
Oswestry

How do they work? The theory is that if a patient does too poorly on a test, especially if he or she does worse than chance, he or she KNOWS the correct answer and is intentionally answering the questions incorrectly to appear impaired.

However, there are a number of problems with this proposition.

Many courts reject the ability of one witness to comment on the credibility of another.[2] That is simply the job of the jury. Malingering tests are nothing more than doctors claiming science backs their ability to call the plaintiff a liar.

A person can still have a brain injury/physical injury/depression regardless of his or her scores on "malingering" tests.

The results of "malingering" tests does not permit one to conclude, with any accuracy, just what percentage, if any, of the testimony the plaintiff has given is true or untrue. Furthermore, "malingering" tests do not permit one to conclude anything about future testimony or acts.

Malingering tests were created by having individuals "pretend" to malinger. How would they know how true malingerers would behave? That's why "malingering studies have often been criticized because the circumstances under which research subjects falsify [their symptoms or performance] differ from those under which real malingerers operate."[3]

The fact that a person may not try hard on a test can be an example of low motivation which can be entirely consistent with Major Depression. In fact, the DSM TR suggests that, "Even the smallest tasks seem to require substantial effort.[4]

Assuming someone is malingering or lying because they do poorly on a test that most people pass does not consider:

- The patient may actually just not care (Anhedonia: symptom of depression)
- The patient may not trust that the doctor will honestly believe him or her so it is, in effect, a cry for help.
- Remember, individuals with brain damage may have problems with motor function (i.e., taking a malingering test on a computer, i.e., Word Memory Test) or difficulty in seeing (visual field abnormalities) and may miss a great number of questions just based upon the location on the page.
- Furthermore, hearing may be a problem and instructions may not be heard or understood. Nonetheless, the defense doctor will automatically conclude MALINGERING.
    - Carpal tunnel syndrome
- If the test requires the use of a computer (MMPI2, Word Memory Test) and your client has no experience in computer use (some people have "computer anxiety")
    - Difficulty reading
    - Extreme anxiety

  Interference from the doctor (cell phone rings, door opens OR, what I call the T.T.I.E. – I had a doc who was always finding my male clients to do so poorly on the malingering tests they must obviously be faking. I sent a videographer.

[2] *Lenz v. Commonwealth*, 261 Va. 451, 469, 544 S.E. 299, 301 (2001); *Kimberlin v. PM Transport, Inc.*, 264 Va 261, 266, 533 S.E.2d 665, 667 (2002); *Feller v. State*, 637 So.2d 911 (Fla 1994). *See also, Mills v. Red Wing Carriers, Inc.*, 127 So.2d 453 (2d DCA 1961)

[3] David Faust & Margaret A. Ackley, *Did you Think It Was Going To Be Easy? Some Methodological Suggestions for the Investigation and Development of Malingering Detection Techniques*, Detection of Malingering During Head Injury Litigation (1998)

[4] Am. Psychiatric Ass'n. *Diagnostic and Statistical Manual of Mental Disorders*, 350 (4th ed. 1994)

What did I see? Hooboy. It was funny. There is my poor client, eyes glazed, drool dripping from the corners of his mouth. Why? The doctor used a "psychometrician" who is the person who actually gives the test. Many states require no formal training for this position. The "psychometrician" was really a very attractive aerobics instructor, heavily endowed, giving tests that required bending over (in a low cut tight dress) and showing the plaintiff cards etc. I call that the Ta Ta Interference Effect).

- Anger. Many brain injured patients have increased irritability. They don't want to be in the room with the defense 'ho. They know they are not going to get a fair break. They are angry anyway and have poor impulse control. Therefore, doing poorly is the equivalent of telling the doctor to fuck off. Example: a teenage girl misses EVERY SINGLE QUESTION on a malingering test. Why? She was sooooo pissed. How did I know? Well, one of the tests involved the COWAT or Controlled Oral Word Association. That involves telling the patient to come up with as many words as they can starting, say, with the letter "F."

Like "Food"

"Famine"

"Friendly"

You get the point. This young girl? HER F words?

"Fucking"

"Fricking"

"Flaming "

"Faggot"

Hmmmm. Think might have some anger issues???

- Brain injury. Brain injured patients get distracted very easily and have problems focusing. Sure, they CAN answer each question but they don't because they lose focus. If the doctor claims that even people with Alzheimer's disease can pass this test, ask him at what level in the course of the disease were these guys used? In other words, if you get some guy who was in early stages of Alzheimer's disease, he might do much better and have better cognition than someone with severe brain injury.

- Pain. Everyone knows pain can interfere with concentration. Doctors have often testified this does not apply to "malingering" tests. No matter how much pain the plaintiff is in. At times like that it's a good idea to take this nonsense to the extreme.

"Doc, you are telling me that no matter how much pain my client is in, it will not affect his ability to perform this test, answer questions correctly, etc, right?:"

"That's correct, counselor"

"Come on, doc, doesn't intense pain interfere with concentration, even on this test?"

"Nope"

"Doctor, do you have children?"

"Yes, why?"

"Doctor, were you present when they were born?"

"Yes."

"So, when your wife was dilated 10 centimeters and in the middle of a contraction you said 'honey, I'm going to give you this here malingering test because I think you are exaggerating the pain in those contractions and I want you to pay attention and focus.'

"You give the test."

"Are you really going to sit here and say that pain won't interfere with the questions?"(assuming, of course, your wife let's you live after your little experiment)

Malingering tests cause the doctor to lie to the patient or, at a minimum, behave in a deceitful manner. When a doctor administers the "Word Memory Test" they may tell the patient he or she will be given a memory test and it will be difficult. That test is neither a memory test nor is it difficult. It is actually quite easy. NONE of the "malingering" tests are given in a straightforward manner. "Here, I am going to test your motivation to see how much you might be REALLY trying. I am going to try and catch you not trying hard." Recently, the deposition of a nationally known neuropsychologist, who administers malingering tests, testified in response to a question as to whether he was misleading the plaintiff when administering the malingering test because he introduced the test as difficult. The testimony below reveals how bad this can make a doctor look. There is no juror out there who will be comfortable with a doctor who is trying to justify lying to a patient.

Q. Okay. Something about them being difficult but do the best you can kind of thing?
A. That kind of thing.
Q. That's actually a lie, isn't it, Doctor? It's not a -- they're not difficult and in fact they're not a memory test. They're a test to see if they're malingering; and to give the test, it requires you to lie to the patient?
A. Well, yeah, that's probably fair.[5]

He or she may do quite poorly on the test and incorrectly be labeled a malingerer. False accusations of malingering are harmful not only to your case, but to your client as well. TAKE the malingering test yourself. Understand it. Research the weaknesses. Do not, however, absolutely DO NOT instruct your client on how to take the test. It's unethical. Period.

I'm proud to say that I can count on one hand the number of times lawyers who retain me ask me how their client could "beat" the test. In fact, no one has ever come right out and said it. Only a few attorneys have given vague hints in that direction.

[5] *Trotter et al. v. Washington Group Int'l. et al.*, Case No: A466763, Dept No: V111 (D.C. Clark Co. NV 2004), Deposition of Lees-Haley

This is why I prefer to never meet or speak to the plaintiff until AFTER all testing is completed. There can be no question that anything like that occurred.

Personality assessment tests have built in scales to see if the patient might be exaggerating good qualities (custody dispute) or exaggerating psychopathology (personal injury claim) this does not mean the doctor can generalize and conclude the patient is faking everything. This finding merely invalidates the test results meaning the only reliable data are from the plaintiff's doctor (assuming the plaintiff passed validity scales in that test).

There are many Games Defense Doctors Play with "Malingering" Tests or Neuropsychological Test in General

Often bad guys will ignore the multiple validity scales within these tests and claim malingering by relying, on, say, poor scores on Trailmaking A (which is NOT a malingering test but, in fact, a test of executive function of the brain)

> "So, Doctor, my client was given the MMPI2 and passed ALL validity scales, for example, the:
>
> Vrin
> Trin
> L
> K
> Fp
> Fb
> F
>
> (these are various validity scales within the MMPI2 designed to determine whether the individual gave true effort and the test results are reliable)
>
> "Let's see now, that's SEVEN different scales to tell us if the plaintiff is approaching the test in an honest and straightforward manner and he PASSED them all."
>
> "You conclude malingering depression based on the PASAT which was never created as a malingering scale, has no manual permitting or even encouraging the test to be interpreted in such a way nor does it have any standardized scoring manual and doesn't test depression, right?"

I have to say, sadly, that each example of manipulation of data and test results actually happened in real cases.

You may even need the doctor to read into the record what the test was created for as indicated in the manual if he or she is claiming something to the contrary.

This can be investigated by simply asking if the test was actually created for the purposes of determine malingering.

What if there IS no test manual?

When these tests are administered, I always subpoena the test manuals. Why? Because often there aren't any! There are no formal scoring manuals either. Translation: The doctor has free reign to claim they mean anything. Many states may have codes of ethics requiring the psychologist to rely upon adequately normed data. So, not only does this method violate codes of ethics, it is also not scientifically reproducible and is not, therefore, permitted to make it to the jury.

You can also look to the American Psychological Association's Code of ethics on this topic.

> **9.09 Test Scoring and Interpretation Services**
> (a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.
>
> (b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence).
>
> (c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.[6]

What if the test really was created to determine your client was malingering? How do we know your client flunked? Always ask the score that the MANUAL says represents flunking and ask the doctor if the patient actually flunked pursuant to the manual's scoring method. I can't tell you how often the doctor claims the patient flunked, then when presented with the manual admits, per the manual, the patient PASSED and cannot cite the science behind his or her own creative scoring. Nauseous yet?

What if your client was administered several trials of a test and passed most but not all? The defense oriented doctor is quick to claim that gives him the right to conclude overall malingering. Demand he or she show you WHERE in the manual that is permitted.

Furthermore, frequently, if the test IS administered and the patient passes, the defense doctor may leave that particular piece of information out of his or her report. I've had a doctor admit he doesn't report when patients PASS malingering tests, only when they flunk. He admits he has NEVER in over 20 years, EVER testified a plaintiff was telling the truth and frequently finds they are malingering. Some doctors may, for example, administer the California Verbal Learning Test. One of the tests is called the Forced Choice component. This

[6] http://www.apa.org/ethics/code2002.html

portion of the test has been used by some as a malingering scale. Defense doctors will report that poor scores are indicative of malingering and when they pass this portion that fact will be **left out of the report.** Translation: I'm only going to report evidence that supports the side retaining me. That's baaaaaaad.

If the doctor concludes malingering but conducted no standardized malingering studies, what do you do? POINT IT OUT!

"Doctor, do you own tests used for malingering or response bias? You own them and didn't give them. Could it be you were worried the plaintiff would PASS?"

The doctor does malingering test but doesn't score it- happens all the time.

Also, the doctor does malingering test then lies about cutoff scores. The doctor claims pain scales are actually malingering scales.

If a client was given a test and does poorly then the doctor claims it is a malingering test. If they do well he or she does not even talk about it or calls it something else. Examples of tests defense typically claim are malingering but NEVER created for that purpose and has no scoring manual permitting that interpretation:

Wisconsin Card Sorting Test
Oswestry
McGill Pain Scale
Modified Somatic Pain Questionnaire
Pain Disability Index

Now, let's discuss some of the actual tests, themselves.

There have been claims on the part of defense doctors that patients learn the tests and then are successful at "beating" them. Therefore, this section will not go into the specifics of how the test is given so that claim cannot be made about this book. However, published criticisms of the tests will be addressed so you, the practitioner, can demand answers from the doctor using the test, and, also, see how this test is abused.

Lees-Haley Fake Bad Scale: This was created by Dr. Paul Lees-Haley to apply to the MMPI2 to determine if the plaintiff is a malingerer. Dr. Lees-Haley selected a number of questions from the MMPI2 and decided that if an individual answered "true" to some of the questions, and "false" to other questions, the conclusion could be drawn, based on how many of these questions were answered in such a fashion, that the individual was malingering.

Now, let's take a look at the science.

The criterion for determining that someone was malingering is not stated in his research. The article introducing this new scale based it on patients that appeared clearly to be malingering. Appeared to whom? On what basis? Was the determination made after data was examined? Did anybody ELSE independently think these people were malingering? Was it confirmed that they were malingering?

Therefore, how is one to reproduce his experiment? It is not possible because he failed to identify how he even determined the individuals in his initial study were malingering. This, of course, may fail a Frye analysis and may not be held to be scientific in accordance with *Frye v. United States*, 293 Fed. 1013 (D.C. Cir. 1923). Regardless of whether your state adheres to Frye standards or some other scientific requirement to be met before testimony is considered scientific, it is certainly an avenue to explore before permitting a doctor to claim science supports his ability to call your client a liar.

In a recent deposition of Dr. Lees Haley, the creator of the test, advised:

> His practice is "almost all defense."[7]
> His practice is so reliant upon defense referrals his template, or pre written report, already indicates the defense hired him before he even receives the referral.[8]
> He treats no patients.[9]
> By the time the case in question comes to trial, his charges could exceed $25,000.00.[10]

This "malingering" scale might just not be appropriate and could explain why Dr. James Butcher, the individual who co-normed the MMPI2, as well as Pearson Assessments, remains so opposed to the use of the Lees-Haley Fake Bad Scale on the MMPI2.[11] When Dr. Butcher looked at the data he found "[t]his scale [sic] shows a bias towards classifying women as malingers" at an even greater rate than convicted felons.[12] This disturbed him. Unless women are, as a rule, less honest than criminals, perhaps there might be a problem. In fact, The Pearson Assessment, the publisher of the MMPI, teaches psychologists not to use this scale.[13]

Dr. Butcher wasn't the only one concerned about this test. "Moreover, the Fake Bad Scale is not likely to meet legal criteria in forensic cases because of the lack of empirical validity and the low level of professional acceptance of it as a measure of malingering."[14]

The Fake Bad Scale does not fit the bill because it greatly overestimates malingering in individuals with genuine psychiatric and psychological problems.[15]

Let's apply this test to a hypothetical plaintiff. Let's say a woman has a car accident with a suspected mild brain

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[7] See *supra* note 5 at 94.
[8] *Id* at 23-25.
[9] *Id* at 68.
[10] *Id* at 93.
[11] James Butcher, et al., *The Construct Validity of the Lees-Haley Fake Bad Scale: Does this scale measure somatic malingering and feigned emotional distress?"* Archives of Clinical Neuropsychology, 18, 473-85 (2003).
[12] *Id* at 482.
[13] *Id.*
[14] *Id* at 473-85.
[15] *Id* at 484.

injury and herniated discs in her neck. She is on narcotics which upset her stomach. She has physical problems causing pain and becomes depressed.

The Lees-Haley Fake Bad Scale gives this woman a point towards malingering for each statement even when the patient is telling the truth.

1. Feeling pain in her neck.
2. Having headaches
3. Having a great deal of stomach trouble (common, by the way, when taking narcotics and/or if suffering from anxiety)
4. Sleep disturbance
5. Having a hard time keeping her mind on his task
6. Feeling like she is about to go to pieces
7. Having more trouble than others concentrating
8. Feeling pressure or stress
9. Feeling tired most of the time
10. Feeling her difficulties were piling up so much she can't overcome them.
11. Having an unsatisfactory sex life
12. Being so sick of what she has to do every day she just wants to get out of it all.
13. Considering killing himself.
14. Tiring quickly.
15. Feeling like everything tastes the same (anhedonia)
16. Having sleep that is fitful and disturbed (pain/depression can certainly cause this)
17. Having trouble with nausea and vomiting (back to side effects of narcotics)
18. Having pains
19. Having nightmares every few nights (anxiety)
20. Everything tasting the same (anhedonia); and
21. God forbid the woman wears glasses. She even gets a point towards malingering if his eyesight has deteriorated over time.

We are now up to 21 points towards malingering when each and every complaint can be clearly and honestly explained by this woman's condition. Keep in mind that a woman only needs a score of 26 to be considered a malingerer.[16] Pretty easy to do if you are hurt, depressed and have a brain injury. In fact, failing the Lees-Haley Fake Bad Scale may be proof of a brain injury not malingering.

An example of this type of problem with this "malingering" test is seen in Dr. Lees-Haley's testimony in a deposition taken in *Trotter, et al. v. Washington International, et al.*:

A: If she is feeling pain in the back of her neck and answers truthfully then that item would be wrong for her.

Q: She would get a point for malingering, according to your scale, even when she's telling the truth. Is that or is that not, Dr. Lees-Haley, correct?

A: If she's feeling pain truthfully and answers the question truthfully, yes.[17]

Minnesota Multiphasic Personality Inventory, 2. This test is the oldest most widely accepted personality inventory in the world. An individual is told to answer 567 true false questions. Based upon his or her answers, assumptions are drawn. For example, an individual with a certain pattern of answers might be similar to how a depressed population might answer the question. Therefore, one might conclude that the individual taking the test might be depressed.

Built within the test are certain scales to determine whether the individual was answering honestly or exaggerating psychopathology. The F scale is the scale defense doctors most often abuse. This stands for "frequency of items endorsed" meaning that someone who is exaggerating might answer true to questions that he believes people whom are depressed would answer. However, true depressed individuals would not answer that particular question in such a way. A high score can give one pause to consider exaggeration.

Often, an individual with concentration problems secondary to a brain injury or depression will score elevated in scale 8 of the MMPI2.[18]

Scale 8 is known as the schizophrenia scale. The unsophisticated or unscrupulous doctor may claim the elevation on scale 8 is meaningless or proof your client is a schizophrenic and therefore it is CLEAR the condition is not related to an injury. On the other hand, the doctor can claim it has nothing to do with concentration.

Upon cross, these doctors will have to admit that many of the MMPI2 questions dealing with concentration are found in this scale. If necessary, have the doctor read the questions that make up that scale into the record. If he or she objects, saying he or she cannot publish actual questions because they are copyrighted and threaten test security, point out the book, "MMPI in Court" by Dr. James Butcher is sold on http://www.amazon.com and it has ALL of the questions of the MMPI in it.[19]

Modified Somatic Pain Questionnaire. That questionnaire consists of 13 questions asking about the

[16] Paul Lees-Haley, *Efficacy of MMPI2 Validity Scales and MCMI-II Modifier Scales for Detecting Spurious PTSC Claims: F, F-X, Fake Bad Scale, Ego Strength, Subtle-Obvious Subscales, DIS and DEB*, Journal of Clinical Psychology 48, 681-89 (Sept. 1992)

[17] See *supra* note 5, at 262.

[18] Nils R. Varney & Richard J. Roberts, *The Evaluation and Treatment of Mild Traumatic Brain Injury*, 297 (1999)

[19] Kenneth S. Pope, James N. Butcher & Joyce Seelen, *The MMPI, MMPI2 and MMPIA- In Court 1- A Practical Guide for Expert Witnesses and Attorneys*, Am. Psychological Ass'n. (2d. 1999)

type of pain experienced by the patient. If the patient endorses pain he or she actually has, and it is severe, he is labeled a malingerer. If he does not, the doctor can then conclude there is nothing wrong with him or her. WHAT A LOAD OF CRAP!!!

Portland Digit Recognition Test. This alleged malingering test has also been criticized for research showing that "interference format may make this technique as much a measure of working memory as anything else."[20]

Rey's 15 Item Test. This test also has problems. Some research shows that 27% of those tested in malingering range when only 15% were actually instructed to fake.[21]

Furthermore, research also shows, "Not only do some patients with focal memory disturbance do poorly on this test, but those with more diffuse cognitive impairment may perform poorly as well."[22]

WAIT JUST A MINUTE! That means if someone does poorly on this test, IT ACTUALLY SUPPORTS a diagnosis of brain damage! Don't let these guys claim poor scores mean malingering. But wait, that's not all. "Some studies show that patients with severe psychiatric disorders were prone to poor performance..." [23] Is your client elderly? Watch out. "[I]n combination with other non-motivational factors, older adults may be erroneously classified as malingering."[24] So, if your client does poorly that can also indicate the presence of severe psychopathology and NOT malingering!

Test of Memory Malingering (TOMMS). According to the TOMMS manual itself, any individual scoring below a 45 on any trial is considered to be in the range of potential malingering.[25] That means if you score less than a 90% on this test you flunk. Do you know any teachers that use such a rigorous system? If they dared to even try to flunk students who got 90% correct there would be a line of angry parents at their door.

Furthermore, there are some potential problems with the test itself. The influence of psychological distress is not known further, additional studies of reliability and validity (e.g. its utility w/respect to other measures to detect malingering) are needed.[26] A review of the TOMMS manual itself confirms that the test was validated with "at risk" malingerers and "simulated malingerers." Translation: no malingerers in normative study so --WE DON'T EVEN KNOW HOW MALINGERERS WILL ANSWER THIS TEST. Further translation: NOT SCIENTIFIC.[27]

"The diagnosis of malingering should NEVER be made exclusively on the basis of the score on the TOMMS."[28] Furthermore, the manual indicates same page "in medicolegal contexts, one should not jump to the conclusion that all fabrications or exaggerations of symptoms are motivated by financial gain."[29] The manual also cautions that the diagnosis of malingering is of limited clinical utility.

Also, malingering is not an all or none phenomena. Malingering does not exclude the possibility that a bona fide symptom might exist. Finally, the very reason we all file motions in limine for the M word- "the diagnosis of malingering is one of the most pejorative clinical judgments because, in essence, it accuses the individual of willful deceit, fraud, and perjury."[30]

Victoria Symptom Validity Test. This is a test designed to assess whether someone is exaggerating memory complaints. This test has limitations such that:

> "Even in cases where financial or other incentives exist, and the patient's performance is suspect, the patient may be legitimately impaired and/or acting without conscious intent. For example, patients with impaired judgment (perhaps reflecting executive dysfunction) may exhibit by chance-level performance."[31]

Word Memory Test. This test is often given by computer. As discussed previously, that fact alone may cause problems in accurate completion. Older versions were computer scored and printed out documents indicating very clearly that, if the individual passed, the answers were given, essentially, in an honest and straightforward manner. Interesting enough, I had a doctor on a case and the actual print out was missing from the raw data in his file. I suspected it was because the plaintiff PASSED the test and the doctor didn't want that data in the file where someone like myself might make a poster sized trial exhibit of that quote.

Sure enough, after the judge ordered the doctor to produce the word memory test print out. There it was. The conclusion of the doctor was that my client was malingering. The computer printout, however, indicated no evidence of malingering.

Interesting.

Now. I do not like this test. Why? Because I see too many clients, clients whom I sincerely believe are trying their best, clients who pass other malingering scales, flunk the WMT.

In fact, recently a plaintiff's lawyer AND the treating psychologist took this test. They tried their best.

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[20] Muriel Lezak, *Neuropsychological Assessment*, 773 (4th ed. 2004)
[21] Otfried Spreem & Esther Strauss, *A Compendium of Neuropsychological Tests, Administration Norms and Commentary*, Administration MS and Commentary at 675 (2d 1998)
[22] *Id* at 673.
[23] See *supra* note 20 at 779.
[24] See *supra* note 21 at 675.
[25] Preston W. Tombaugh, *TOMMS Manual* (1996).
[26] See *supra* note 21 at 677.
[27] See *supra* note 25 at 16.
[28] *Id* at 19
[29] *Id.*
[30] *Id.* at 21
[31] See *supra* note 21 at 684.

Often articles may support a conclusion that certain scores support the conclusion of malingering on these pain tests. DO NOT TAKE THIS AT FACE VALUE.

Concern is expressed about the funding sources of individuals creating these malingering tests. If one follows the dollar, it may very well begin with an insurance company.

Perhaps the bias of the researcher should be considered. Bias in publications has long been a serious problem (over-reporting and/or withholding responses).[32]

In fact, recent research reveals concealment occurs in data reporting in a MAJORITY of the cases.[33]

An observational study found that authors of randomized controlled trials frequently use concealment of randomization and blinding, despite the failure to report these methods.[34]

Educate yourself on the defense's nickel. In depositions use cross examination to learn more about the tests because when you do, you AND the jury will be outraged.
Demand to see the test.
Demand to see the answers.
Demand to see the test booklet that permits you to administer and interpret this test in such a fashion.

Was the test, for example, created with a normative sample of patients with low back pain and is it applied to your client who suffers from complex regional pain syndrome? Ahhh, the normative sample is not the same. Complex regional pain syndrome (CRPS) can be so severe one of the sequella can be *suicide.*

So, if your client was not represented in the normative sample so we don't know how people with CRPS will react when they take this test so we cannot apply this test to those individuals. How do patients answer this test when they also are dealing with a condition that is so painful they want to die?

The American Psychological Association makes it very clear the normative sample must include patients like those upon which the test is applied.

> **9.02 Use of Assessments**
> (a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.
> (b) Psychologists use assessment instruments whose validity and reliability have been established **for use with members of the population tested.** When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.
> (c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.[35]

Hmmmm. Since we don't know if people like your client will answer this test in the same fashion as the normative sample, then we cannot apply this test to that individual.

Let's take a look at a concrete example. A few years ago I was teaching MMPI2 issues in Cuba. Amazingly, the scale measuring paranoia was more highly elevated in Cubans than Americans.[36] Should the Cubans have been labeled paranoid in a society where free travel is restricted, the government monitors advertising, movies, news and freedom of expression is a concept not a reality? (Sounds like I'm described the United States, doesn't it?). No. Their answers reflected reality, not paranoia.

Time to ask the sensitivity/specificity test.

Doctor, are there ANY publications that give us the sensitivity and specificity (how accurate at diagnosing brain damage or ruling it out based on the combination of your choices of tests? NOTE: I did not ask about each individual test. Some will have published data. I am talking about the COMBINATION of tests chosen.

Draw a bag. Put lots of dots in the bag. "Doctor, these dots represent tests you chose to give. How accurate is THIS BAG of tests, taken as a whole, in ruling in or out brain damage?" Answer? NO CLUE.

"Now, doctor, if you gave a standardized/rigid battery of tests, those figures DO exist, don't they? For example, there is published data on how accurate the Halstead Reitan is in ruling in or out brain damage if you give the whole battery of tests, right?"

But not for what you did, right? And, according to the draft code of the Coalition of Clinical Practitioners in Neuropsychology, what you did was unethical, right?"[37]

A good neuropsychologist will admit that even if one believes in malingering, it is still relatively rare even in brain injury cases.

> "This issue has been dealt with above, and will be only briefly summarized here. Simply put, it is

[32] PA Higham, *Strong cues are not necessarily weak: Thomson and Tulving (1970) and the encoding specificity principle revisited*, Memory and Cognition, 67-80 (Jan. 2002).
[33] J. Clin. Epidemoil12, 57, 1232-36 (Dec. 2004).
[34] PJ Devereaux, et al., *Need for expertise based random control trials*, Department of Medicine, Department of Clinical Epidemiology and Biostatistics McMaster University, (Jan. 2005).

[35] http://www.apa.org
[36] R. Velasquez & M. Garrido *Handbook of Latino MMPI-2 Research and Application*, Chapter by Karina M. Quevedo & James N. Butcher (Lawrence Erlbaum Press 2003).
[37] Coalition of Clinical Practitioners in Neuropsychology, *Code of Ethics for Coalition of Clinical Practitioners in Neuropsychology* at http://www.neuropsych.com/CCPNgoals.htm

the exception, not the rule, to find clients who are consciously using their deficits to their advantage. The vast majority of head injured patients are extremely frustrated and very eager to get on with their lives.

Unfortunately, it is true that a learned dependency is often established; many head injured persons become so used to others doing for them, that they come to believe that they are incapable and must be dependent, and therefore resist efforts to get them to do more things on their own.

While this process is insidious, common in clients who have been home and inactive for years, and absolutely destructive to the rehabilitation process, it is not malingering.

Learned dependency is by definition learned and therefore can be unlearned. Malingerers, however, become more resistant, not less, as they are forced to do more. Most."[38]

Physical Malingering Tests:

Waddell's signs. Often medical doctors will claim that positive Waddell's signs are evidence of malingering. This is not true. Waddell signs consist of doctors performing physical maneuvering such as non-axial loading, wherein the doctor pushes the top of the patients head and asks if it elicits low back pain. Physiologically it cannot. If the patient claims that it does, the doctor concludes evidence of malingering. This is an incorrect use of the signs. They were originally created to determine whether the patient needed a psychiatric referral, NOT for malingering. In fact, Waddell signs are a poor predictor of malingering.[39]

It is interesting that the defense doctors will frequently use the Waddell's for this purpose but never, ever refer the plaintiff to a psychiatrist. They just leap to the lying conclusion.

The lawyer is urged to watch a video of the examination. Often the patient will bend when his/her head is pushed and that CAN cause low back pain. Perhaps the patient may even DENY the pain contrary to the doctor's testimony. Furthermore, often in the exam the attorney will find that the doctor claimed to have performed certain physical tests that were never performed.

Recently, in trial, I asked a doctor about the "Normal" neurological exam.

Q. Doctor, throughout your report is "WNL" correct?
A. Yes
Q. Doctor, your testimony was that WNL stood for "within normal limits", is that correct?
A. Yes.
Q. Doctor, isn't there another term of art in your profession that says "WNL" actually stands for "WE NEVER LOOKED?"
A. Uh, well, yeah.

Jury gets the point.

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[38] Thomas Kay & Muriel Lezak, *Traumatic Brain Injury and Vocational Rehabilitation* at http://www.getrealresults.com/tenmyths.html.

[39] David A. Fishbain, et al, *A Structured Evidence- Based review on the Meaning of Nonorganic Physical Signs: Waddell Signs*, Pain Medicine 4 (June 2003).

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Feature Story

Attorney carves niche cross-examining experts who say plaintiffs are malingerers

By Patty Morin Fitzgerald Contributing writer

Dorothy Clay Sims was so incensed by one medical expert who said more than 50 of her clients were malingerers that she devoted her career to unmasking the hired guns who masquerade as medical experts.

While working as a plaintiffs' lawyer at a five-lawyer firm in Ocala, Fla., Simms devoted years to studying the testing methods used to determine whether a person is faking his or her injuries. Her goal was to become so knowledgeable about the testing methods that she could quickly spot when a doctor was scoring the tests inappropriately to come up with the answer her opponent wants.

Because there is no one definitive test for malingering, many doctors are trying to promote their own tests as the industry standard, according to Sims.

"It's disgusting. People are being denied healthcare. People are dying because they're not getting healthcare," Sims said. "These tests the doctors make up with no science. I asked this one doctor, 'You claim my client doesn't have brain damage with what kind of test?' 'I made it up,' he said."

While conceding that some defense medical experts are honest, Sims believes the percentage is very low. She said that when she first launched her specialty, she returned from a deposition and was "shaking I was so mad."

"Then I decided I would make a plate of homemade cookies, and if they were honest, I would give it to them," she

said. "In the last 12 months, I've done that twice. And I do depos every day."

Defense lawyers not to blame

Sims has concluded that in many cases the fault is not with defense attorneys. She noted that many are directed to hire certain experts by their clients' insurance companies and are not aware of the inaccuracies or shady test results produced by their witnesses.

"It's not so much the lawyers themselves who are at fault. It's the doctors," she said. "When doctors spin medicine, lawyers don't know enough about medicine to catch it. The jury is impressed with a guy with 30 years experience, [even if he's] making things up. This stuff works for them."

Sims said she believes that defense lawyers are often taken by surprise when she demonstrates the shoddiness of their expert's methodology.

"In the real world it's difficult to keep on top of your cases and know the nuances of medicine too," she said. "I often see that they're surprised, too. I'm lucky my husband is a doctor and he can give me advice."

The number of true malingerers seeking her services is rare, she said, though it has happened. There have been times when she has rejected a case because the person's claims do not seem legitimate.

But she said it would be extremely difficult for someone to fake an injury over the years required for most cases to work their way through discovery, depositions and trial.

Picking apart the expert

Sims recently worked on a case that involved an older gentleman who suffered head, neck, back and brain injuries in a 2003 car accident. In his lawsuit, the man claimed he suffered constant pain, especially after prolonged sitting or walking. He said he couldn't work due to fatigue, headaches, sleep problems and leg numbness that made it difficult to drive. He also claimed that his cognitive and emotional difficulties caused him to lose interest in social activities he had enjoyed with his wife prior to the accident and that she had essentially become his nurse.

Sims was hired by the plaintiffs' team to fend off challenges the defense planned to mount against these assertions.

During a background search, her own medical consultants uncovered an affidavit indicating the defense's medical

expert had misrepresented findings in another case and presented it to the jury. With the defense expert's credibility shot, the plaintiff won more than $2 million, she said.

Sims said her success isn't due to any special brilliance, but simply to the fact that she is accustomed to these doctors, their tactics and their language.

Based on her experience, Sims has a great deal of advice on how plaintiffs' lawyers can reveal the shoddy techniques and trumped-up conclusions of disreputable medical experts.

Preparing for depositions

When Sims plans for depositions - which she takes all over the country - she uses a checklist of techniques that have worked repeatedly for her over the years. Based on this experience, she suggests that lawyers:

- Use the Freedom of Information Act to acquire background information about the doctor which can be used to impeach his or her testimony. Among the most damaging findings she's made was a doctor who was accused of taking narcotics from his patients and had been dismissed from his job at a university.
- Bring a laptop with an Internet connection so you can challenge the doctor to produce the articles he is using to back up his testimony. If he declines to find material, it's a safe bet there isn't any. This works particularly well in video depositions.
- Have a plastic bag on hand, and if you suspect the doctor has not reviewed the medical records, have them sealed in the bag and tell the doctor that you intend to have them checked for his fingerprints. "I had one case where none of the pages were dog-eared and they looked like they had never been touched. I asked him, 'Are you absolutely sure you reviewed these pages.' He said 'Yes.' So I pulled out the plastic bag and told him I was going to have the reports fingerprinted. "No wait, wait," he said, and he admitted he may not have reviewed them. This was a video deposition, so I had it all on tape."
- This can also work if you suspect a document has been altered in any way. Have it sealed in the bag and tell the doctor you intend to have the ink date-tested. "Then sit back and watch the fireworks," said Sims.
- In an attempt to appear unbiased, doctors frequently claim that they work nearly as often for plaintiffs they do for defendants. If you suspect this isn't true, present the list of cases he has worked on and ask him to mark the ones in which he testified for the plaintiff. The first time Sims used this, the doctor said that he testified about a third of the time for plaintiffs. But when presented with the list, he was only able to identify about 5 percent of the cases in which he testified for plaintiffs, according to Sims.
- Collect pamphlets in the doctor's waiting room to see if they describe symptoms that mirror your clients' complaints - then use them to challenge the expert.
- Check with organizations for plaintiffs' attorneys in the area to get the names of past cases the expert has testified in. Then get transcripts of those depositions to see if there have been any inconsistencies in his or her statements over the years that you can exploit.

- Have a court reporter present at the deposition to create a digital transcript that can be searched quickly on the computer. If there is a discrepancy with prior testimony, you are better able to challenge the doctor. If you cannot afford a court reporter, use a tape recorder.
- Acquire any books or articles the doctor has written and quote from them. During one deposition Sims caught a doctor disagreeing with something he had written in his own book.

Evaluating the raw data

Many researchers have tried to sell tests they have developed as the definitive test to determine malingering, but the one used most often is the MMPI (Minnesota Multiphasic Personality Inventory). Sims said this test is "well-validated" and effective if used the right way.

But, it can often be unreliable when it is a case of a "good test in the hands of a bad doctor."

So when confronted with the MMPI, Sims asks the expert how he or she administered and rated the test and compares that with the instructions to expose any inconsistencies that could render the results invalid. This often requires you to demand to see the test booklets and all the raw data.

Another thing to watch for is experts who administer the test several times with different results, then use only the results that favor the defense position.

When tests other than the MMPI are used, lawyers should ask several additional questions:

- Was the test version and scoring culturally appropriate for the plaintiff?
- If the test was given verbally, were the questions worded to elicit a specific answer?
- Was the test older and scored based on outdated criteria? Sims noted a phenomenon known as "the Flynn effect" which shows a steady rise in average IQ scores since 1972. She says this same effect applies to similar psychological tests, which means that if a plaintiff claiming brain damage is given an old test, his score might make his cognitive function appear artificially high.

Sims said that another common test - the Folstein Mini-Mental State Examination - is often not scored properly. This verbal test, which is also used on suspected Alzheimer's patients, is often not given in its entirety and therefore not reported accurately.

The expert battle frequently comes down to a face-off between medical and psychological tests, according to Sims. She has had defense experts totally dismiss medical results and argue the only valid measure is the

psychological battery.

She worked for one woman who suffered three herniated discs in her neck in a car accident that required surgery. Although both a discogram and an EMG (electromyography) indicated disc damage, Sims said the opposing expert's response was "That doesn't mean anything." He had used the Waddell Test and stated the woman's pain was self-inflicted, caused by her own "hysteria."

But when Sims asked whether he had administered and scored the entire test, the answer was, "No." This allowed Sims to make the point, by quoting the test's author, that the doctor had used the test incorrectly, rendering his results suspect.

Likewise, the Halstead-Reitan Neuropsychological Battery has strict protocols that can be used to determine if the results obtained are valid.

Another tool designed to unmask fraud is Rey's 15 Item Memory Test, but it tends to falsely report malingering if a client is elderly or has a low IQ, according to Sims.

One of the more outrageous tests she's encountered is the Lees-Haley Fake Bad Scale, which, according to Sims, finds women to be malingerers far more often than men and raises the subject's malingering score if she wears glasses or has hot flashes from menopause. In fact, Sims said, she has convinced one judge (a woman) to disallow the test.

Questions or comments can be directed to the features editor at: bill.ibelle@lawyersusaonline.com

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Doctor in a box - Software cuts cost of challenging medical experts

In addition to her frequent lectures to lawyer groups, Dorothy Clay Sims has developed an online company designed to help lawyers challenge medical experts.

The company is called MDinaBOX.com, Inc.

She started the company a year ago with her husband, a doctor, while on a trip volunteering for a nonprofit organization in India. Her husband had health problems requiring tests, and they saw how inexpensive medical care was there compared with the United States.

"And they were just brilliant," she said of the doctors in New Delhi.

Doctors here charge $300 to $1,500 per hour as expert witnesses, Sims said, compared with the $20 to $45 per hour, plus bonuses, she pays to communicate with doctors there. She charges her clients $75 to $125 per hour for the consults. Many are of these doctors are board certified, but sometimes she'll hire internists to discuss gynecological issues.

Using Skype, a video conferencing computer program that allows users to speak with each other, MDinaBox allows a doctor in New Delhi listen in at a deposition through the lawyer's laptop, and when the opposing expert says something that is not correct, the Indian doctor instant messages the lawyer with a question she can ask to trip up the witness.

It's a method that's not always popular with opposing counsel.

"If you tell them you have a doctor on live IM, they're uncomfortable because it's new," she said.

But she insists that her consultants' qualifications shouldn't matter because they're not testifying.

On the MDinaBOX.com website, Sims offers a videotaped example of how her service works, showing herself questioning a doctor in this country using information privately IM'd to her from a doctor in India. The young US doctor becomes confused with her directed questioning and ends up contradicting his initial testimony.

We see the defense counsel almost call off the session because there had been no prior discussion about another doctor listening in over the computer.

"I was given no advance notice of a doctor listening in," says opposing counsel. "I object and move we cancel this until we discuss this issue."

But Sims isn't thwarted so easily.

"I object to you canceling this as it has been scheduled for a long time," she says on the video, emphasizing that there is no requirement that opposing counsel be notified about someone listening in who is not testifying.

"This is absurd. Alright, but please do not do this to me in the future," says the opposing counsel.

Sims said she's pleased with the results of her new strategy and that only about a quarter of her cases fail to be settled after the deposition. Her company has attracted roughly 115 customers, eager to find a less expensive

way to obtain medical advice during depositions.

The main office of MDinaBOX, Inc. is in Ocala, Fla., and has five full-time employees. Her New Delhi office has a coordinator, eight researchers who do background checks on medical witnesses and 28 doctors who are independent contractors.

- Patty Morin Fitzgerald

http://www.lawyersweeklyusa.com/subscriber/archives.cfm?page=usa/07/5070737.htm

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Brain Injury and Community Based Issues

Controversies in Neuropsychology

by Dorothy Sims, Esq.

Paul R. Lees-Haley in his recent article appearing in the previous issue of *Brain Injury Professional* discusses what he purports are controversies in the field of forensic neuropsychology. The question that one must ask is whether these are 'real' and accepted controversies or are created and raised by forensic experts who earn a living serving as defense experts for defendants and insurance companies. As the United Supreme Court recognized in *General Electric v. Joiner*, 522 US 136, 146 (1997) an expert's opinion is not admissible only by the ipse dixit of the expert.

Dr. Lees-Haley bemoans bias on the part of doctors diagnosing brain damage. However, where is the concern about the bias of doctors claiming no brain injury exists? For example, Dr. Lees-Haley states:

"How many mild brain injury plaintiffs are malingering, and do we dare admit it?"[1]

"Are substantial numbers of postconcussive complaints iatrogenic effects of contact with lawyers and irresponsible clinicians?"[2]

"The use of self-report data is fraught with controversy."[3]

"Some experts act as if everything causes concussions and concussions last forever."[4]

"These experts persist in diagnosing brain injury regardless of contrary evidence."[5]

"Although the better quality scientific literature clearly indicates the improbability of significant lasting consequences following a mild brain injury, some experts routinely assume they have found exceptions based on self report, even in silly accidents."[6]

Nowhere in his article does Dr. Lees-Haley focus or even admit the bias against brain injuries by those who profit from such testimony the most. In a recent deposition of Dr. Lees Haley, he advised:

His practice is "almost all defense."

His practice is so reliant upon defense referrals his template, or pre written report, already indicates the defense hired him before he even receives the referral.

He treats no patients.

By the time the case in question comes to trial, his charges could exceed $25,000.00.

Is it possible that there could be a built in bias in favor of finding NO brain injury considering the publications one produces and the source from which one's income rises? I ask, instead, How many mild brain injury patients are **falsely** accused of malingering and/or having no brain injury?

Let's use the "Fake Bad" scale created by Dr. Lees-Haley as an example. The Fake Bad MMPI-2 scale was created for use with personal injury claimants to detect response bias and intentional symptom distortion. Let's say a patient has a car accident, hits his head, herniates a disc in his neck. He can no longer work and becomes depressed and anxious. He is on narcotics for pain and pain interferes with his sleep. This is not an uncommon scenario.

The following is an example of why this "malingering" scale might just not be appropriate and could explain why Dr. James Butcher, the individual who co-normed the MMPI-2, as well as Pearson Assessments, remains so opposed to the use of the Lees-Haley Fake Bad Scale on the MMPI-2.

The Lees-Haley "fake bad scale" gives this man a point towards malingering for each statement even when the patient is telling the truth.

1. Feeling pain in his neck.
2. Having headaches.
3. Having a great deal of stomach trouble (common, by the way, when taking narcotics and/or if suffering from anxiety).
4. Sleep disturbance.
5. Having a hard time keeping his mind on his task.
6. Feeling like he is about to go to pieces.
7. Having more trouble than others concentrating.
8. Feeling pressure or stress.
9. Feeling tired most of the time.
10. Feeling his difficulties were piling up so much he can't overcome them.
11. Having an unsatisfactory sex life.
12. Being so sick of what he has to do every day he just wants to get out of it all.
13. Considering killing himself.
14. Tiring quickly.
15. Feeling like everything tastes the same (anhedonia).
16. Having sleep that is fitful and disturbed (pain/depression can certainly cause this).
17. Having trouble with nausea and vomiting (back to side effects of narcotics).
18. Having pains.
19. Having nightmares every few nights (anxiety).
20. Everything tasting the same (anhedonia).
21. And, God forbid the man wears glasses. He even gets a point towards malingering if his eyesight has deteriorated over time.

We are now up to 21 points towards malingering when each and every complaint can clearly and honestly be explained by this man's condition.

Now, keep in mind that a man only needs a score of 24 to be considered a malingerer.

Pretty easy to reach a 24 score if you hurt, are depressed, and have a brain injury. In fact, one could conclude that failing the Lees-Haley Fake Bad Scale is proof of a brain injury instead of malingering.

An example of this type of problem with this "malingering" test is seen in Dr. Lees-Haley's testimony in a deposition taken in the *Trotter, et al v. Washington International, et al,* case:

A: If she is feeling pain in the back of her neck and answers truthfully then that item would be wrong for her.

Q: She would get a point for malingering, according to your scale, even when she's telling the truth. Is that or is that not, Dr. Lees-Haley, correct?

A: If she's feeling pain truthfully and answers the question truthfully, yes.

These: "malingering" tests are not the panacea he and others would have you believe them to be. For example:

1. Many courts reject the ability of one witness to comment on the credibility of another. That is simply the job of the jury.
2. A person can still have a brain injury regardless of his or her scores.
3. The results of "malingering" tests do not permit us to conclude, with any accuracy, just what percentage the individual may be lying about.
4. Malingering tests were created by having individuals "pretend" to malinger and "malingering studies have often been criticized because the circumstances under which research subjects falsify (their symptoms or performance) differ from those under which real malingerers operate."
5. The fact that a person may not try hard on a test can be an example of low motivation which can be entirely consistent with Major Depression. In fact, the DSM TR suggests that, "Even the smallest tasks seem to require substantial effort.

I am confused when he states that "most of us feel that attorneys should **not** have unrestricted access to tests and their answers..., which is directly contrary to his position in his article in *Claims* magazine, a magazine relied upon by the insurance industry wherein he states:

"Psychologists who claim that the ethical code of psychologists prohibits disclosure of tests and raw test data to attorneys, judges and jurors are misinformed...

"Competent psychologists know from the outset that their work will be scrutinized in the context of trial proceedings."

In fact, he goes on to state, "For example, if a psychologist claims an attorney is not qualified to use the data, one must ask, 'Who is better qualified than an attorney to use the data to cross-examine a psychologist?"

He acknowledges, "Without seeing the tests and test data, an attorney cannot possibly fully understand the methodology or the reasoning process used to draw conclusions from test data, and cannot possibly fully cross-examine the expert on the reliability and validity of the allegedly scientific methodology."

It appears, however, that Lees-Haley is only upset that, apparently, the DEFENSE attorney is having difficulty getting the data:

"And if psychologists can give the data to a patient or client, who is a plaintiff, then in effect they are giving it to the plaintiff attorney, but not the defense attorney. So, how can they claim to be unbiased?"

Dr. Lees-Haley thrashes attorneys and plaintiffs in his article. However, I note he fails to address what appears to me to be a serious problem: Why has Dr. Lees-Haley chosen to leave

out the problem of defense bias?

It's time to admit the Emperor has no clothes. There is a potential for bias on the part of doctors who evaluate individuals solely for the defense. A bias that seeks to find malingering regardless of the facts. Since my practice is limited to cross examining defense doctors for other lawyers througout the US, I have seen what appears to be an incredible bias towards doing anything possible to avoid relating symptoms to an injury.

Now, usually these individuals never have to explain their behavior. Why? Because most attorneys don't know that raw data can no longer be hidden pursuant to new HIPAA laws, and even if they got it, they wouldn't understand it.

Ok. Now what?

What about "research" that supports certain answers that lead one to conclude malingering, or, for that matter, the "fact" that most mild brain injured patients are just plain fine? Perhaps the bias of the researcher should be considered. Bias in publications has long been a serious problem (over-reporting and/or withholding responses). In fact, recent research reveals concealment occurs in data reporting in a MAJORITY of the cases. An observational study found that authors of randomized controlled trials frequently use concealment of randomization and blinding, despite the failure to report these methods.

Where in the articles on malingering is it revealed if the author receives the significant bulk of his or her income from the defense who serves to benefit from the article? How about that doctor who cannot come up with ONE single case spanning his or her career wherein he testified he agreed with the treating doctor.

That seems like a pretty important fact that ought to ooze its way into the article.

Conclusion

If one describes malingering as an individual modifying his or her behavior for external gain, does not the potential for that very same problem exist with the doctor him/herself?

Could it be that this type of behavior is based on the territorial protection of a feeding source? There is much more money in forensic neuropsychology than for the poor practitioner who is out there in the fields, arguing with insurance companies who downcode his or her bills, or downright refuse to reimburse for treatment and whose treatment for years may be 1/10th the bill for a single evaluation by a "forensic" neuropsychologist as a result of one of those "silly" accidents. My heart goes out to those fine people, and their poor patients.

REFERENCES

1. Lees-Haley, Paul R., "Forensic Neuropsychology: Still Controversial After All These Years," *Brain Injury Professional*, pp. 6-10, 6.
2. *Id.* at 6.
3. *Id.* at 8.
4. *Id. at 8.*
5. *Id.* at 9.
6. *Id.* at 9.
7. *Trotter et al. v. Washington Group Int'l, Inc. et al.*, Case No: A466763, Dept. No: V111 (D.C. Clark Co., NV), Aug. Deposition of Lees-Haley at page 94.
8. *Trotter et al.*, Deposition of Lees-Haley at pages 23-25.
9. *Trotter et al.*, Deposition of Lees-Haley at page 68.
10. *Trotter et al. v. Washington Group Int'l, Inc. et al.*, Case No: A466763, Dept. No: V111 (D.C. Clark Co., NV), Deposition of Lees-Haley at page 93.
11. Butcher, James, et al., "The Construct Validity of the Lees-Haley Fake Bad Scale. Does this scale measure somatic malingering and feigned emotional distress?", *Archives of Clinical Neuropsychology*, 18 (2003) 473-485.
12. Lees-Haley, Paul.; "Efficacy of MMPI2 Validity Scales and MCMI-II Modifier Scales for Detecting Spurious PTSD Claims: F, F-X, Fake Bad Scale, Ego Strength, Subtle-Obvious Subscales, DIS, and DEB", *Journal of Clinical Psychology*, Vol. 48, No.5, pp.681-89 (September 1992).
13. *Trotter et al. v. Washington Group Int'l, Inc. et al.*, Case No: A466763, Dept. No: V111 (D.C. Clark Co., NV), Aug. 2004, Deposition of Lees-Haley at page 262.
14. *Lenz v. Commonwealth*, 261 Va. 451, 469, 544 SE 299, 301 (2001); *Kimberlin v. PM Transport, Inc.*, 264 Va. 261, 266, 533 SE2d 665, 667 (2002); *Feller v. State*, 637 So.2d 911 (Fla. 1994); *see also, Mills v. Red Wing Carriers, Inc.*, 127 So.2d 453 (2d DCA 1961).
15. Faust, David & Ackley, Margaret A., "Did you Think It Was Going To Be Easy? Some Methodological Suggestions for the Investigation and Development of Malingering Detection Techniques," *Detection of Malingering During Head Injury Litigation (1998)*, Cecil R. Reynolds (ed.).
16. DSM 4th Ed, TR page 350, American Psychiatric Association
17. "Are Psychologists Hiding Evidence? A Need for Reform", *Claims Magazine* (April 2000), pg. 9.
18. "Are Psychologists Hiding Evidence? A Need for Reform", *Claims Magazine* (April 2000).
19. *Id.* at 1-2.
20. *Id.* at 2.
21. *Id.*
22. *Id.* at 1.
23. *Id.* at 2.
24. American Psychological Association Code of Ethics, 11.04, www.APA.org
25. Higham PA, "Strong cues are not necessarily weak: Thomson and Tulving (1970) and the encoding specificity principle revisited"; *Memory and Cognition*, 30(1):67-80 (01-JAN-2002), NIH/NLM MEDLINE, 11958356 (PubMed); Department of Psychology, University of Southampton, Highfield, England.
26. *J Clin Epidemiol.* 2004 Dec;57(12):1232-6.
27. Devereaux PJ, et al., Choi PT, El-Dika S, Bhandari M, Montori VM, Schunemann HJ, Garg AX, Busse JW, Heels-Ansdell D, Ghali WA, Manns BJ, Guyatt GH; Department of Medicine, Department of Clinical Epidemiology and Biostatistics, Faculty of Health Sciences, McMaster University, Room 2C8, 1200 Main Street West, Hamilton, ON, L8N 3Z5, Canada.