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IADC Midyear Meeting

February 11, 2014

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Effective Use of Forensic Psychiatry in Catastrophic Injury, Toxic Torts, and Multi-Party Litigation

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Effective Use of Forensic Psychiatry

- Cases with emotional distress components
- How forensic psychiatry can assist to evaluate claims
- Forensic psychiatric expert v. treating clinician
- Psychological testing
- Remainder of IME
- Issues unique to mass torts
- New DSM-5 criteria for PTSD
- Legal and procedural issues
- Q&A

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Cases Involving Emotional Injuries

- Refinery explosion
- Airplane crash
- Chemical spill
- Toxic exposure
- Serious injury
- Assault
- Harassment
- Discrimination

Emotional Injuries

- Pain & Suffering
- Annoyance & Discomfort
- Emotional Distress
- Fear of Cancer

Pain & Suffering

“Non-economic damages" means subjective, non-monetary losses including, but not limited to, pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation.

Cal. Civ. Code§1431.2

Pain and Suffering

- No claim is being made for mental and emotional distress over and above that usually associated with the physical injuries claimed.

- No expert testimony regarding this usual mental and emotional distress will be presented at trial in support of the claim for damages.

Cal. Civ. Proc. Code § 2032.320

Annoyance and Discomfort

Annoyance and discomfort damages are intended to compensate a plaintiff for the loss of his or her peaceful occupation and enjoyment of the property … [which] generally refers to distress arising out of physical discomfort, irritation, or inconvenience caused by odors, pests, noise, and the like. * * * Our cases have permitted recovery for annoyance and discomfort damages on nuisance and trespass claims while at the same time precluding recovery for "pure" emotional distress.

Kelly v. CB&I Constructors, Inc., 179 Cal.App.4th 442 (2009)

Emotional Distress

Emotional distress includes suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame. Serious emotional distress exists if an ordinary, reasonable person would be unable to cope with it.

CACI 1620 (NIED)

Emotional Distress

"Severe emotional distress" is not mild or brief; it must be so substantial or long lasting that no reasonable person in a civilized society should be expected to bear it. Plaintiff is not required to prove physical injury to recover damages for severe emotional distress.

CACI 1604 (IIED)

Fear of Cancer

Plaintiff must prove:

- That plaintiff was **exposed** to benzene as a result of defendant's negligence;
- That plaintiff **suffered serious emotional distress from a fear** that he will develop cancer as a result of the exposure;
- That reliable **medical or scientific opinion confirms** that it is **more likely than not that plaintiff will develop cancer as a result of the exposure**; and
- That defendant's negligence was a **substantial factor** in causing plaintiff's serious emotional distress.

CACI 1622

Forensic Psychiatry

What is forensic psychiatry and how can it assist to evaluate and defend claims?

ON WEARING TWO HATS:

The Profound Differences Between Treaters and Forensic Psychiatric Experts

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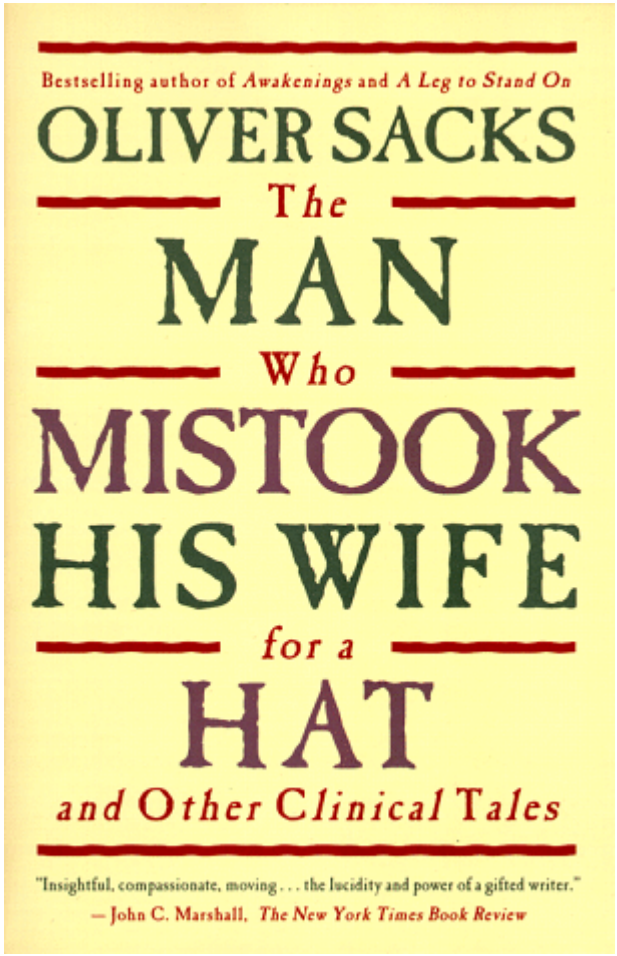
The Problem with Wearing Two Hats is…

Role Confusion…



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Mission, Method & Ethical Duty: Treating Clinician vs. Forensic Expert

TREATING CLINICIAN:

Mission: To alleviate suffering (Hippocratic Oath)

Method: Relies almost exclusively on patient's self-report of *subjective* reality.

Ethical Duty: To the patient (Hippocratic Oath) – *advocates* for patient's best interests

Mission, Method & Ethical Duty: Treating Clinician vs. Forensic Expert

INDEPENDENT FORENSIC PSYCHIATRIC EXPERT:

Mission: To determine what is *objectively* true

Method: Reviews all medical/legal/employment documents AND performs objective (neuro)psych testing AND conducts detailed psychiatric IME interview exam

Ethical Duty: Provides evidence-based opinions to the trier of fact

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Emotional Distress Claims: Types of Mass Torts

- Natural Disasters
- Man-made Disasters
- Toxic Torts
  - Mold
  - Water Supply Contamination
  - Exposure to Chemicals and/or Radiation
  - Fear of Cancer
- Discrimination

Description of Psychiatric IME

Components:

- Psychological
  (& Neuropsych if indicated)
  Testing:

Description:

- Precedes Psychiatric Examination
- Psych (4 - 6 hours)
- Neuropsych (6 - 8 hours)

- Psychiatric Examination:

- Detailed Psychiatric History
  (4 – 6 hours)
  - Including developmental, medical, psychiatric, medication, substance use, relationship, educational, employment, legal (civil & criminal), military histories & history of event.

Description of Psychological & Neuropsychological Testing

- Which tests?
- What do they tell us?
- What follow-up?
- Different approaches to testing.

What is a Test?

- Psychometrically Validated Instrument
- Correlated with Identifiable Disorders
- Controls for Positive and Negative Bias
- Identifies Base Rates in the General Population
- Routinely Used and Relied Upon within the Scientific Community

What is Not a Test?

- Symptom Checklists
  - Useful for GP's or Family Doctors
  - Help Direct Referrals
  - Little Value in Forensic Examinations
  - Encourage Bias
  - Frequently Demonstrate Exaggeration
  - Relied Upon by Plaintiff's Experts

Personality Tests Without Validity Scales

- Commonly Used Symptom Checklists:
  - Beck Depression Inventory I & II
  - Beck Anxiety Inventory
  - CAPS Clinician Administered PTSD Scale
  - SCID Structured Clinical Interview for DSM-IV
  - Sentence Completion Test
- All Rely upon Self-Report Only

Personality Tests With Validity Scales

- **MMPI-2** (Minnesota Multiphasic Personality Inventory)
- **PAI** (Personality Assessment Inventory)
- **MCMI-III** (Millon Clinical Multiaxial Inventory-III)

  - Psychometrically Standardized
  - Contain Validity Measures for Positive and Negative Bias
  - Help Identify Malingering

Mold Exposure

ELSEVIER

Archives of Clinical Neuropsychology 22 (2007) 533–543

Archives of CLINICAL NEUROPSYCHOLOGY

Neuropsychological exploration of alleged mold neurotoxicity

Matthew J. Reinhard [a,*], Paul Satz [a], Cris A. Scaglione [b], Louis F. D'Elia [a], Yuri Rassovsky [a], Anthony A. Arita [a], Charles H. Hinkin [a], Delaney Thrasher [a], Gary Ordog [c]

Abstract

Cognitive and emotional correlates of toxic mold exposure and potential dose–response effects for both outcomes were investigated. Self-reported length of exposure, time since last exposure, and serum immunoglobulin (IgG) levels were assessed. Despite CNS complaints often seen with mold exposed individuals, overall results did not uncover concomitant cognitive deficits suggested in previous studies or a significant reduction in intellectual functioning. Fewer subjects were excluded as result of failing effort/motivation assessment than expected. Correlations of IgG and cognitive function are discussed. A dose-effect for self-reported length of exposure and cognitive outcome was not seen. The sample's overall Minnesota Multiphasic Personality Inventory II (MMPI-2) profile indicated elevations on scales 1, 2, 3, 7 and 8. MMPI-2 clinical scales 1 and 3 were significantly correlated with length of exposure. The MMPI-2 may be sensitive to increasing physical and emotional sequelae as length of exposure increases. A potential subgroup of cognitively impaired outliers within mold exposure litigants is explored. Limitations of self-reported and objective measurements for mold exposure and exploratory statistical methodology are discussed.

Rorschach

- Comprehensive System by Exner
  - Widely Used for Many Years
  - Psychometrically Based
- RPAS Rorschach Performance Assessment System
  - Newest Scoring System
  - Cross Cultural Normative Data

➢Both Supported by the Society for Personality Assessment (SPA)

Reliability and Validity of the Rorschach

- The Society of Personality Assessment's Endorsement of the Rorschach, Published in the Journal of Personality Assessment, 85(2), 219-237, 2005
- This statement is intended for psychologists, other mental health professionals, educators, attorneys, judges, and administrators. Its purpose is to present a summary of the issues and evidence concerning the Rorschach.
- This statement affirms that **the Rorschach possesses reliability and validity similar to that of other generally accepted personality assessment instruments and its responsible use in personality assessment is appropriate and justified.**

Neurocognitive Tests

- **WAIS-IV** Wechsler Adult Intelligence Scale-IV
- **WMS-IV** Wechsler Memory Scale-IV
- **CVLT-II** California Verbal Learning Test – II
- **WCST** Wisconsin Card Sorting Test
- **STROOP** Stoop Color and Word Test
- **COWA** Controlled Oral Word Association
- **VOT** Hooper Visual Organization Test

Mild Traumatic Brain Injury

- PROGNOSIS FOR MILD TRAUMATIC BRAIN INJURY: RESULTS OF THE WORLD HEALTH ORGANIZATION COLLABORATING CENTRE TASK FORCE ON MILD TRAUMATIC BRAIN INJURY
- J Rehabil Med 2004; Suppl. 43: 84–105
- **We searched the literature on the epidemiology, diagnosis, prognosis, treatment and costs of mild traumatic brain injury. Of 428 studies related to prognosis after mild traumatic brain injury, 120 (28%) were accepted after critical review. These comprise our best-evidence synthesis on prognosis after mild traumatic brain injury. There was consistent and methodologically sound evidence that children's prognosis after mild traumatic brain injury is good, with quick resolution of symptoms and little evidence of residual cognitive, behavioral or academic deficits. For adults, cognitive deficits and symptoms are common in the acute stage, and the majority of studies report recovery for most within 3–12 months. Where symptoms persist, compensation/ litigation is a factor, but there is little consistent evidence for other predictors. The literature on this area is of varying quality and causal inferences are often mistakenly drawn from cross-sectional studies.**

Computerized Tests

- Usually derived from paper and pencil tests
- Reliability and Validity usually not as good
- More prone to manifest false positive results
- Less control by the examiner
- Usually used as screening instruments
- Require cross validation with interactive testing between examiner and subject

Symptom Validity Tests

- **WMT** Green's Word Memory Test
- **TOMM** Test of Memory Malingering
- **CARB** Computerized Assessment of Response Bias
  - ➢Most Widely Used and Relied Upon
  - ➢Highest Reliability and Validity
  - ➢Helpful in Identifying Malingering

Symptom Validity Tests

- At least 2 Symptom Validity Tests are necessary as part of any Brain Injury Evaluation

Archives of Clinical Neuropsychology,20 (2005) 419–426

- National Academy of Neuropsychology (NAN) position paper: "Symptom validity assessment: Practice issues and medical necessity"

- NAN Policy & Planning Committee:
  - Shane S. Bush,Ronald M. Ruff, Alexander I. Troster, Jeffrey T. Barth,Sandra P. Koffler, Neil H. Pliskin, Cecil R. Reynolds, Cheryl H. Silver

Analysis of Test of Results

Are the test results valid?

- Is there a consistent pattern of findings?
- Greater consistency = greater reliability
- Do self-endorsement tests = projective tests?
- Self-report findings better than projective?
- Self-report findings worse than projective?

Psychosomatic Patients

Do the symptoms = objective findings?

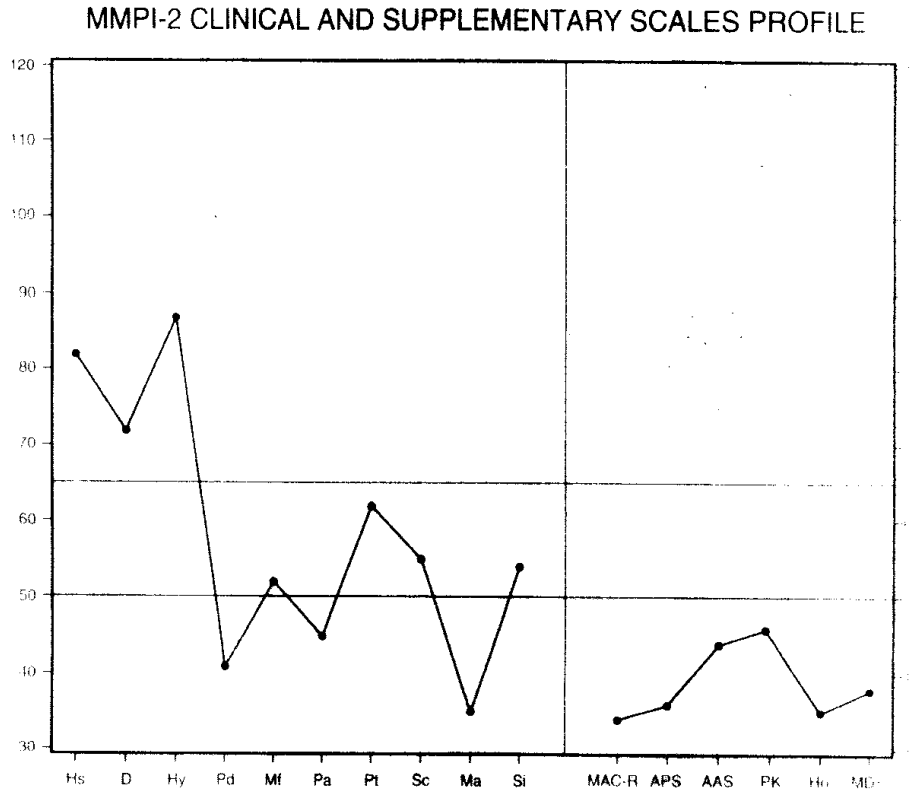
- Is there evidence of exaggeration in the tests?
- Does research correlate with psychosomatic explanations?
- Is there a history of vague and changing complaints that cannot be fully explained?
- Have the complaints arisen after exposure to stress?
- Is there evidence of secondary gain?

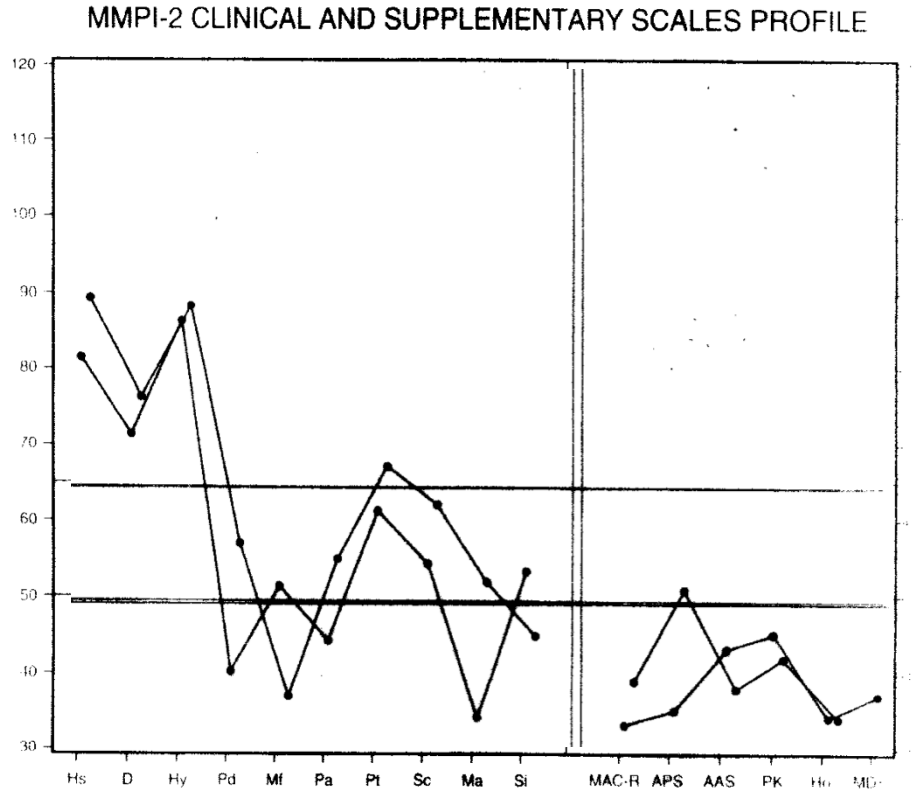
Case Illustration

- 3 Adult females living in the same house.
- All claim psychological and cognitive impairment due to mold exposure.
- All claim disability due to profound impairment.
- They were unaware of their impairment until they leaned that another family previously lived in the same house and had the same problems.
- They used the other family's doctor to confirm their problems.

Results of Assessment

- All had normal cognition.
- No impairment with attention, concentration or memory.
- No findings of brain impairment.
- Subjective complaints greater than objective findings.
- Test results consistent with psychosomatic illness.





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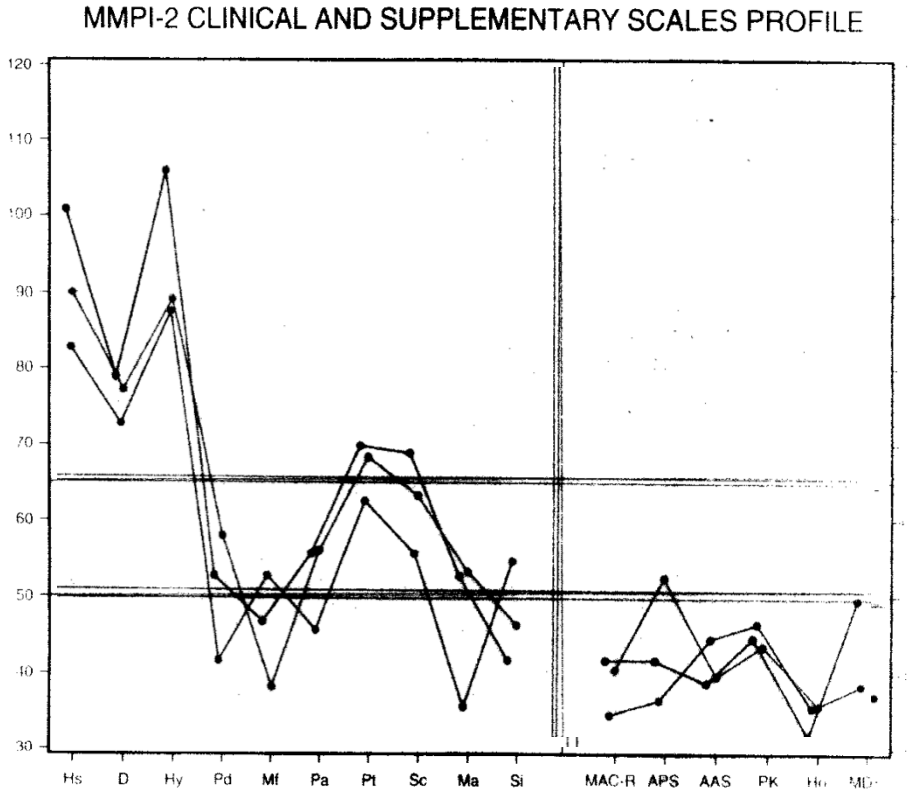

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Check Out the Data

- Do not accept opposing experts reports without "raw data" when psychological tests were administered and summarized
  - Have "raw data" analyzed by your own psychological expert and re-scored if needed
  - Opposing experts may underplay or completely omit highly significant psychological test data from their reports

Stipulated Protected Order

- Stipulates test data may be turned over to the other side and will not be kept as part of the public record (or will be sealed); they may not be used for any other purpose apart from the present litigation; and they will not be copied or distributed in any form outside the present litigation
- Best way to get access to test data
- Protects psychologists from ethical concerns
- Avoids conflicts between attorneys and psychologists

Standard Procedures & Dismissal of Evidence

- American Psychological Association (APA)
- "Test Administrators should follow carefully the standardized procedures for administration and scoring specified by the test publisher"
  - **Standards for Educational and Psychological Testing of the American Psychological Association**
- Failure to follow standardized procedures may constitute an ethical violation (unless there is a compelling reason to do so)
- *Daubert* finding

Psychiatric IME Report

- **Summary of evidence-based opinions and conclusions.**
  - Diagnoses, if any, with explanations.
  - Psych testing any any other objective data.
  - Functional impairment, if any.
  - Statement of causation.
  - Prognosis.
  - Recommended treatment and estimated costs.
  - Differences, if any, with opposing expert(s).
- **Assignment: "For whom am I working?" & questions to be addressed.**
- **Sources of information:**
  - Summaries and chronologies of documents reviewed.
  - Summary of events resulting in litigation; Plaintiff(s)' claims.
  - Report of psychiatric examination, detailed history, symptoms, etc.

Issues Unique to Mass Torts

- Advantages of a psychiatric & psychological assessment team vs. assembling a panel of individual experts.
- Screening and examining a representative sample vs. entire population.
- “Normal” or Bell distribution curve of damages.
- Problems with sampling if chosen by plaintiffs’ and defense counsel – the “barbell” effect.
- Increased accuracy and credibility of forensic opinions when population is assessed by one team of experts.

Advantages of a Psychiatric & Psychological Assessment Team vs. Assembling Your Own Panel of Individual Experts

1. Experience With Mass Tort Population Assessments.
2. Quality of Individual Experts.
3. Cohesion – Team Used to Working Together.
4. Collateral Informants – Each Examined Claimant is a Collateral Informant for Every Other Claimant.
5. Increased Accuracy and Credibility of Forensic Opinions When One Population is Assessed by One Team of Experts: Ability to Compare Uninjured Claimants With Injured Claimants.

Screening and Examining a Representative Sample vs. Entire Population

Issues Related to Sampling:

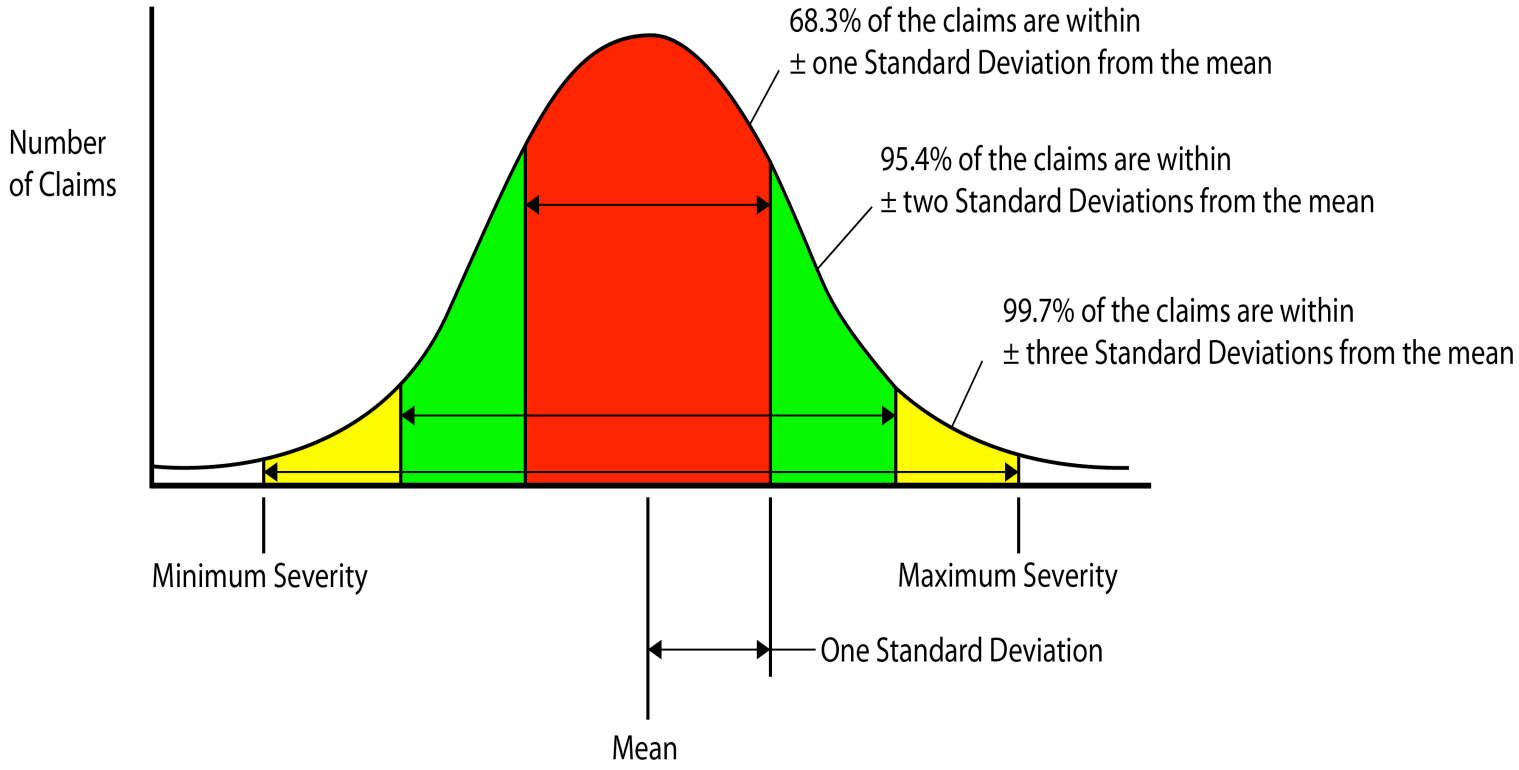
"Bell" Curve

vs.

"Barbell"

Distribution of Damages Produced by a Catastrophic Event:

A Gaussian (Normal) or "Bell" Curve Distribution of Claims



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Problems with Sampling If Claimants Chosen by Plaintiffs' and Defense Counsel

The "Barbell" Effect

Defense counsel=
no damages

Plaintiffs' counsel =
significant damages

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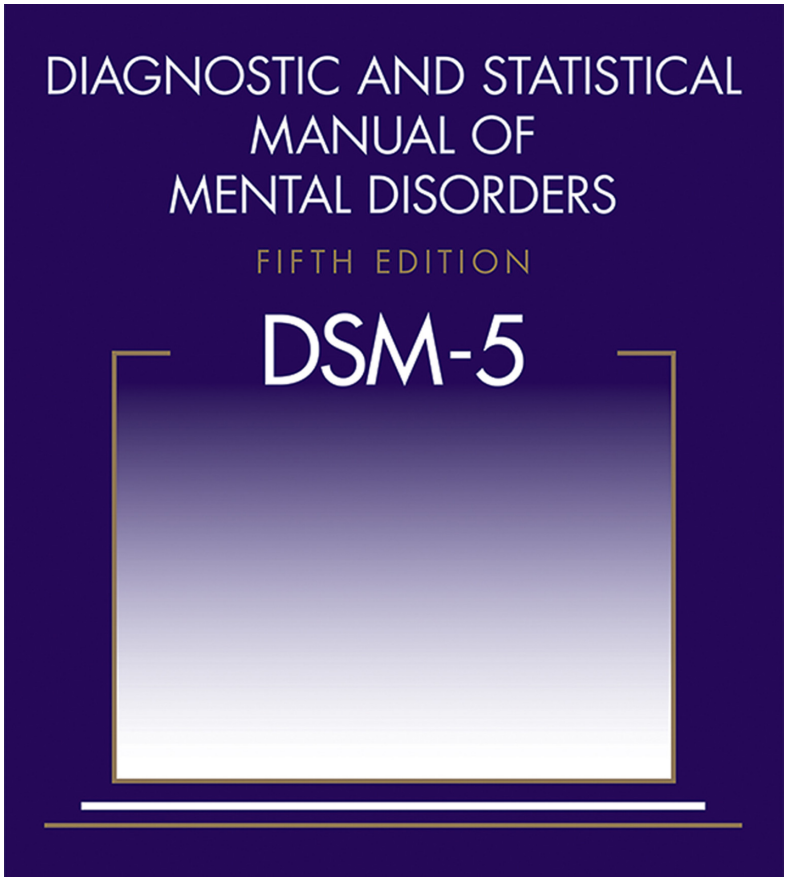
Changes from *DSM-IV* to New *DSM-5*



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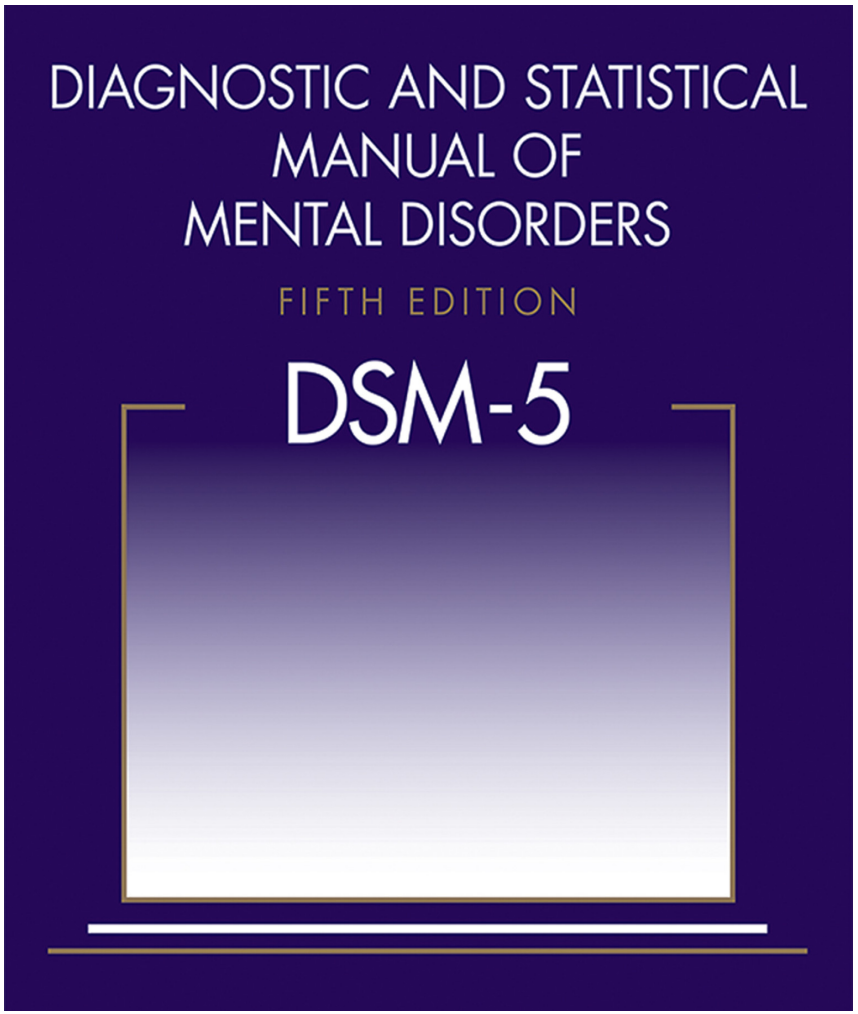
Mental Illness & the Potential Impact for Litigation of the New *DSM-5*

Section I. Cautionary Statement for Forensic Use of *DSM-5*



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Cautionary Statement for Forensic Use of *DSM-5*

…it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals…..

Cautionary Statement for Forensic Use of *DSM-5*

When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations…By providing a compendium based on a review of the pertinent clinical and research literature, **DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders** … Finally, diagnostic information about longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

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Cautionary Statement for Forensic Use of *DSM-5*

However, the use of *DSM-5* should be informed by an awareness of the risks and limitations of its use in forensic settings…there is a risk that diagnostic information will be misused or misunderstood. *These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis….*

Cautionary Statement for Forensic Use of *DSM-5*

…the clinical diagnosis of a *DSM-5* mental disorder… ***does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard*** (e.g., for competence, criminal responsibility, or disability) … additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question.

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Cautionary Statement for Forensic Use of *DSM-5*

Use of *DSM-5* to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised … Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

Perceived Shortcomings of *DSM-IV*

- High rates of co-morbidity
- High use of NOS category
- Treatment non-specificity
- Inability to find laboratory markers/tests
- DSM is starting to hinder research progress
  - NIMH launched Research Domain Criteria (or RDoC): a 10-year effort to define mental disorders based on behavioral and brain measures
  - DSM's approach by contrast relies on rulings by groups of psychiatrists about which symptoms characterize particular disorders.
  - Thomas Insel, MD, NIMH Director: "This approach has yielded imprecise diagnostic labels that advance neither treatment nor research."

Major Structural Changes from *DSM-IV → DSM-5*

- **DSM-5 STRUCTURAL CHANGES**:
  - Axis I through V Removed
  - Some Diagnoses Removed, others Added
  - Section III – Emerging Models and Measures Added
  - Attempt to Combine Dimensional Approach with DSM's Set of Categorical Diagnoses

PTSD Criteria: Differences Between *DSM-IV* & *DSM-5*

- ***DSM-5*** criteria for **PTSD** differ significantly from the DSM-IV criteria, e.g.:
  - The stressor criterion (Criterion A) is more explicit with regard to events that qualify as "traumatic" experiences.
  - Also, DSM-IV Criterion A2 (subjective reaction) has been eliminated.

PTSD Criteria: Differences Between *DSM-IV* & *DSM-5*

- ***DSM-5*** criteria for **PTSD** differ significantly from the *DSM-IV* criteria:
  - Whereas there were three major symptom clusters in *DSM-IV*—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in *DSM-5*, because the avoidance/numbing cluster is divided into two distinct clusters:
    - avoidance and
    - persistent negative alterations in cognitions and mood. This latter category, which retains most of the *DSM-IV* numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states.

PTSD Criteria: Differences Between *DSM-IV* & *DSM-5*

- ***DSM-5*** criteria for **PTSD** differ significantly from the DSM-IV criteria:
  - The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable behavior or angry outbursts and reckless or self-destructive behavior.
  - PTSD is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents.
  - Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

DSM-5 PTSD Diagnostic Criteria 309.81

(Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.)

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

DSM-5 PTSD Diagnostic Criteria 309.81

B. Presence of one (or more) of the following **intrusion symptoms** associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

  Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

  Note: In children, there may be frightening dreams without recognizable content.

- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

  Note: In children, trauma-specific reenactment may occur in play.

- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

- Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

DSM-5 PTSD Diagnostic Criteria 309.81

C. **Persistent avoidance of stimuli** associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

DSM-5 PTSD Diagnostic Criteria 309.81

D. **Negative alterations in cognitions and mood** associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1 Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2 Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3 Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4 Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5 Markedly diminished interest or participation in significant activities.

6 Feelings of detachment or estrangement from others.

7 Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

DSM-5 PTSD Diagnostic Criteria 309.81

E. **Marked alterations in arousal and reactivity** associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1 Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2 Reckless or self-destructive behavior.

3 Hypervigilance.

4 Exaggerated startle response.

5 Problems with concentration.

6 Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

DSM-5 PTSD Diagnostic Criteria 309.81

F. **Duration** of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance **causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

H. The disturbance is **not attributable to the physiological effects of a substance** (e.g., medication, alcohol) or another medical condition.

DSM-5 PTSD Diagnostic Criteria 309.81

Specify whether:

- **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
  - **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
  - **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).
  - **Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

DSM-5 PTSD Diagnostic Criteria 309.81

Specify if:

- **With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

- **Posttraumatic Stress Disorder for Children 6 Years and Younger** (see modified criteria)

Legal and Procedural Issues

Need for Discovery

vs.

Privacy Interests

Legal and Procedural Issues: *Prima Facie* Proof

For mass torts and/or class actions, employ use of a "Lone Pine" or other case management order that requires each plaintiff to present prima facie proof of his/her emotional distress injury and its connection to the incident, with a report or declaration from a forensic psychiatrist establishing the connection.

Legal and Procedural Issues: IMEs

- Order to conduct IME?
  - FRCP 35
  - Cal. Civ. Proc. Code § 2032.320
- Multiple examiners:
  - Does the jurisdiction permit more than one "exam"?
- Recording?
  - Audio generally permitted
  - Video preferred
- Attendance by third parties?
  - Generally disfavored
  - *Ragge v. MCA/Universal Studios,* 165 F.R.D. 605 (C.D. Cal. 1995)
  - *Golfland Entertainment Centers, Inc. v. Superior Court,* 108 Cal. App. 4th 739 (2003)

Legal and Procedural Issues: Practical Considerations

- IME provides evidentiary support for claim – evidence that may not have previously existed
- Battle of the experts
- Jury misunderstands distinction between the forensic psychiatrist (objective) and the treater (subjective) – demonstrates need for an effective communicator as the expert

Thank You

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