

Chapter 2

Employment Evaluations and the Law

Introduction

In the previous chapter, we addressed psychiatrists' and psychologists' professional ethical obligations to third parties who contract for disability and disability-related evaluations, to the subjects of these evaluations, and to the courts and administrative tribunals asked to resolve relevant disputes. In this chapter we address the legal obligations attendant upon these evaluations. Psychiatrists and psychologists should be familiar with both. Ethical codes describe what the majority of a profession expects of its members and may be based on the same moral principles as the law (Bersoff, 1995). However, ethical and legal obligations may be congruent or incongruent. Ethical codes do not bind the law (i.e., legislatures, courts, agencies), which may have different expectations on any given issue based on a different moral perspective.

For example, the professional ethical duty of confidentiality, which prioritizes effective psychotherapy, conflicts with legal norms that prioritize accurate dispute resolution. Moreover, the ethical duty of confidentiality does not limit the authority of a judge to order disclosure and punish noncompliance. That is the realm of the law of privilege.

Claims of forensic professional liability or malpractice, although relatively rare, are brought against psychologists and psychiatrists (Binder, 2002; Gold & Davidson, 2007; Greenberg et al., 2007; Heilbrun et al., 2008; Melton et al., 2007). To prevail in a malpractice case, the complainant would have to demonstrate that the outcome of the claim would have been different if the mental health professional had not performed in a substandard manner. In addition, other types of legal obligations relating to the provision of disability and disability-related evaluations do exist and require that those providing such evaluations be familiar with the legal obligations and framework within which they are conducted.

Operating at the interface of the mental health professions and the law can create challenges in understanding conflicts and priorities in clinical evaluations conducted for legal or administrative reasons. Even psychiatrists and psychologists with a good understanding of the legal issues related to clinical

evaluations conducted for treatment purposes may find themselves caught in a no-man's land of competing legal obligations when conducting disability and disability-related evaluations. Although disability and disability-related evaluations have much in common with clinical evaluations conducted for therapeutic purposes, the legal rules that govern the two differ.

Understanding the rules governing disability and disability-related evaluations begins with the recognition that they are most often applied outside the courthouse and are not subjected to public scrutiny. No codified list of what must be included in these evaluations or how they should be conducted has been established. Often, cases or statutes specific to disability and disability-related evaluations do not exist and we rely on general principles of contract or tort law. In other instances, precedent setting cases involving physicians are available, but not involving psychiatrists or psychologists. When no argument that might persuade courts to reach a different result in the case of psychiatrists or psychologists is evident, we present relevant cases involving other clinical specialties to explain the law. Because many disability and disability-related evaluations are conducted at the request of a third party, we begin with how the retaining third party and the examiner's expectations for the evaluations are expressed.

Obligations to the Retaining Party in Employment Evaluations

Most mental health professionals begin their assessments of both ethical and legal obligations from the perspective of the physician–patient relationship. It may therefore seem odd that a discussion of legal obligations in disability and disability-related evaluations begins with the obligations to the third party who enters into the contract with the evaluating clinician. However, a discussion of legal obligations in disability and disability-related evaluations needs to begin with an understanding that the contract in such evaluations is between the evaluating clinician and a third party, not between the evaluating clinician and the evaluatee. Beginning the legal discussion of disability and disability-related evaluations with this subject also reflects legal history in which tort law, as we know it today, was a relatively late arrival. Liability arising out of the breach of an agreement has a longer legal pedigree.

The contract between the evaluating mental health professional and the third party requesting the evaluation is the primary relationship in third-party evaluations as far as the law is concerned. The vast majority of disability and disability-related evaluations performed by psychiatrists and psychologists are not conducted for the benefit of the courts and are never judged by them. Risk assessment and fitness-for-duty evaluations, for example, are typically intended only for the private use of a third-party employer. Examinees who think they were wronged by the evaluation face a fundamental problem posed by the absence of a doctor–patient relationship, discussed in the section “A Question

of Duty” found below. But the relationship between examiners and the employers or insurance companies who retain them and who feel the examiner has wronged or harmed them does not pose the same problem.

First and foremost, evaluators owe a duty to the retaining party to provide competent evaluations. Substandard evaluations violate a contractual duty owed to the party who employed the evaluator (*Ryans v. Lowell*, 1984). When these evaluations subsequently arise in a lawsuit asserting that the failure to identify serious health problems that cost the employer money for which it seeks recompense, the question they present is whether the evaluation met the expectations of the parties (*Marine Transp. Corp. v. Methodist Hosp.*, 2006). The courts evaluate and determine whether the evaluation was conducted with the agreed-upon level of competence and skill.

Explicit agreements between the parties to a contract regarding performance standards are controlling. When an explicit agreement articulating a different standard does not exist, the courts default to the tort standard of reasonable professional conduct as a performance measure (*Lambley v. Kameny*, 1997). Inability to meet that threshold because it is beyond the examiner’s expertise risks nonpayment for contracted services as well as tort liability for any resulting harm.

Consider, for example, *Marine Transp. Corp. v. Methodist Hosp.* (2006). On behalf of Marine Transportation, Methodist Hospital and Rashid Khan, M.D., conducted a fitness-for-duty examination of seaman Richard Guillory and failed to identify the presence of syphilis, from which Guillory died on a ship in the plaintiff’s employ. The employer then sued Methodist Hospital and Dr. Khan for the costs of Guillory’s medical care on the ship. After receiving a chilly reception in the trial court, the Texas Court of Appeals upheld the claim. Under Texas law, the physician is a party to a contract for the patient’s benefit and in the absence of evidence that the parties chose a different standard of care, Methodist and Khan were required to exercise a duty of reasonable care.

Consent

Although many disability and disability-related evaluations are arranged by the contracting third party, consent of the evaluatee, as in the provision of all health care, is generally required by the law as well as professional ethics. Psychiatrists and psychologists enjoy no roving authority to intervene in the lives of others. Captured in Cardozo’s colorful and much-quoted refrain highlighting the importance of autonomy, the fundamental legal principle underlying the necessity for consent is now beyond debate. “[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body....” (*Schloendorff v. Society of New York Hospital*, 1914, p. 93). The law’s recognition of autonomy extends to the mental as well as the physical realm (*Zinermon v. Burch*, 1970).

Whether in a private employment context or a court-ordered examination, consent should precede the evaluation and no evaluation should proceed without consent (*Smith v. Welch*, 1998). In the case of court-ordered examinations (although unlikely in disability and disability-related evaluations), consent, or, as some prefer, assent, is constitutionally required if statements made during the examination may be used against the evaluatee in a criminal proceeding (*Estelle v. Smith*, 1981). Proceeding with an evaluation without assent is also unwise. Obtaining consent, even if not absolutely necessary or mandatory, costs nothing and treats the examinee with respect. Failing to obtain a consent later determined to be required cannot be remedied.

Despite the contract with the third party, evaluatees must therefore make a stark but meaningful choice that the examiner should respect (Foote & Shuman, 2006). Refusing to participate in an employment evaluation has its consequences: evaluatees may lose financial benefits or employment. The law has upheld the rights of employers to obtain such evaluations in certain circumstances. For example, employers are permitted to require employees to submit to fitness-for-duty examination as a condition of employment if it is job related and enjoys a business necessity (*Cal. Gov. Code*, 2004). “Simply put, applicants for jobs . . . have a choice; they may consent to the limited invasion of their privacy resulting from the testing, or may decline both the test and the conditional offer of employment” (*Wilkinson v. Times Mirror Corp.*, 1989, p. 194). Even though these consequences may seem harsh, the examinee is entitled to make his or her own choice.

Other rules may also play a role in encouraging an informed decision about participation in disability and disability-related evaluations. In some states, the results of a court-ordered examination may be admitted if it can be shown that the evaluatee was previously informed the examination would not be privileged (Tex. R. Evid. 510 (d)(4)). Providing information to the examinee about the absence of privilege makes it more likely that the true nature and purpose of the relationship and the risks and benefits that may flow from the examination are addressed.

In the context of treatment, the elements of adequate or “informed consent” generally consist of information provided regarding “(1) the condition being treated, (2) the nature and character of the proposed treatment, (3) anticipated results, (4) possible alternative treatments, and (5) possible and probable risks and side effects” (*Barcai v. Betwee*, 2002, p. 959). Different interests are at stake in nontherapeutic employment or forensic evaluations (Foote & Shuman, 2006). The information exchange that must precede a valid consent/assent is generally thought to include informing the evaluatee of the *purpose* of the examination; who will have access to the results of the examination or at least to whom the report will be forwarded; and of what the examination will consist (e.g., pencil and paper tests, interviews). Examinees should also be advised that no treatment will be provided at the time of the evaluation or in the future. Before the examination begins, an examinee should know whether the sole

purpose of the examination is to discover information relevant to a claim or defense and not to provide treatment.

If there is any doubt about whether the evaluee understands these conditions at any time during the assessment, mental health professionals should explain them as many times as necessary during the course of the interview. If the evaluation is occurring in the context of litigation and the examiner has concerns about the evaluee's understanding of these conditions, examiners should refer the evaluee to his or her attorney before proceeding. Examiners should obtain a signed consent before beginning the interview documenting that all these conditions have been explained. In the absence of a valid consent/assent, or relevant exception thereto, evidence resulting from the evaluation may not be admissible and the examiner may face a tort claim for battery, intentional infliction of emotional distress, invasion of privacy, or negligence.

Obligations to the Evaluee in Disability and Disability-Related Evaluations

A psychiatrist or psychologist conducting an employment evaluation wields immense power over the person being evaluated. When individuals perceive they have been harmed by an inappropriate evaluation, given the important role of work in peoples' lives, it should not be surprising that they may pursue professional disciplinary actions or civil tort remedies measures. The professional disciplinary process associated with inappropriate or substandard evaluations was discussed in Chapter 1. This discussion will address the tort remedy.

Most tort claims arising out of a disability and disability-related evaluation assert negligent rather than intentional wrongs. Intentional tort claims such as battery, intentional infliction of emotional distress, or false imprisonment are possible in the employment context and apply even if no doctor-patient relationship exists (*Smith v. Welch*, 1998). However, the assertion that a health-care professional intentionally harmed an evaluee they had not met until the evaluation presents an assertion that is intuitively unlikely and difficult to prove. Thus, negligence is the mainstay of these claims.

Negligence is the breach of a duty proximately causing harm. The conjunctive elements necessary in a claim of negligence are proof of duty, breach, cause, and harm. Duty refers to the legal recognition of an obligation to another; breach refers to conduct that does not meet that obligation; cause refers to a close connection between the breach and the harm claimed; and harm refers to injury that the law recognizes. Each must be found to be more likely than not for the plaintiff to prevail.

In many instances, courts have treated these relatively new tort claims arising out of third-party evaluations as ordinary negligence rather than as medical

malpractice. Medical malpractice or professional negligence, that is, intentional and negligent tort claims against health-care professionals, applies the same basic principles as ordinary negligence with a few added wrinkles. Although most medical malpractice claims are grounded in negligence, important procedural consequences flow from their categorization as “ordinary” negligence (Gold & Davidson, 2007). For example, some tort reform efforts are limited to cases designated as medical malpractice. In addition, medical malpractice claims generally have shorter statutes of limitation than ordinary negligence claims; medical malpractice claims are more likely to require expert testimony on the standard of care; and medical malpractice claims are more likely to be covered under a professional liability insurance policy.

The Question of Duty in Third-Party Evaluations

Duty, the first element of negligence, is an issue that is likely to be contested in malpractice claims arising out of disability and disability-related evaluations because of the nature of the doctor–patient relationship in a third-party evaluation. When contested, the question of whether a duty exists is ordinarily determined by the judge. If the judge determines as a matter of law that the defendant owes no legal duty to the plaintiff, the lawsuit will be dismissed without regard to the harm the plaintiff suffered.

The common law took the position that in the absence of voluntarily assuming an obligation (e.g., when taking on a new patient), no one, not even health-care professionals, has a legal duty to come to the aid of another. In the event of a request for emergency or nonemergency services, with limited exception (see Emergency Medical Treatment and Active Labor Act; also *Greenberg v. Perkins*, 1993), mental health professionals legally have the choice of accepting or not accepting a patient for treatment. Accepting the patient for treatment gives rise to a doctor–patient relationship and resultant legal duties.

In contrast, courts have held that an evaluation conducted for the benefit of a third party does not give rise to a doctor–patient relationship and, consequently, a duty of care. Therefore, the majority rule in such cases is that a traditional medical malpractice claim by the examinee against the evaluator will not survive (*Joseph v. McCann*, 2006; *Martinez v. Lewis*, 1998; *Rogers v. Horvat*, 1975; *Tomko v. Marks*, 1992). “The general rule is that the physician who is retained by a third party to conduct an examination of another person and report the results to the third party does not enter into a physician–patient relationship with the examinee and is not liable to the examinee for any losses he suffers as a result of the conclusions the physician reaches or reports” (*Ervin v. American Guardian Life Assur., Co.*, 1988, p. 357).

For example, in *Joseph v. McCann* (2006), Joseph, a Salt Lake City police officer who shot a motorist, was required to submit to an independent medical examination (IME) regarding fitness for duty as a condition of reinstatement.

McCann, a psychiatrist, performed the IME and concluded that Joseph was not psychologically fit to perform his duties as a police officer. After unsuccessfully appealing his termination with the city, Joseph brought a malpractice claim against McCann. The trial court dismissed the claim on summary judgment. The Appeals court ruled that a fitness-for-duty examination does not result in a physician–patient relationship cognizable in an action for medical malpractice by the examinee, and affirmed reasoning that a physician–patient relationship was a prerequisite to a legal duty enforceable in a medical malpractice action. Because McCann was not treating or evaluating Joseph for treatment, no physician–patient relationship arose and no medical-malpractice claim would be recognized. Thus, a false-positive finding that results in failing a fitness-for-duty evaluation done at the behest of a third party is not grounds for a medical malpractice claim in most states. Similarly, in another case, *Harris v. Kreutzer* (2006), the Virginia Supreme Court refused to recognize a medical malpractice claim brought against a psychologist for an incorrect diagnosis in an employment evaluation.

However, mental health professionals conducting disability and disability-related evaluations should be aware that although a doctor–patient relationship is the foundation for a malpractice claim, no particular formalities are necessarily required to establish that relationship. A relationship may be established without a written document reflecting the terms or conditions of the relationship or even without direct contact. Neither doctor nor patient may realize the implications of their actions. The test courts apply to determine whether a doctor–patient relationship existed asks what a reasonable person observing their behavior would believe, not what the doctor or the patient believed (Baum, 2005).

It is the general rule that recovery for malpractice against a physician is allowed only where there is a relationship between the doctor and patient This relationship may be established by contract, express or implied, although creation of the relationship does not require the formalities of a contract, and the fact that a physician does not deal directly with a patient does not necessarily preclude the existence of a physician-patient relationship. What is important, however, is that the relationship is a consensual one, and when no prior relationship exists, the physician must take some action to treat the person before the physician-patient relationship can be established (*Dehn v. Edgecombe*, 2005, p. 620).

For psychiatrists and psychologists conducting disability and disability-related evaluations, slipping into a clinical role in a forensic evaluation, or agreeing to provide future services for a forensic evaluee may establish a doctor–patient relationship. Doing so exposes the examiner to liability for medical malpractice, in addition to creating the ethical and practical problems discussed in Chapter 1.

The “no-duty-to-rescue” rule has been unpopular for many years because it is morally abhorrent. Highly publicized cases of bystanders failing to take any action to stop a sexual assault or a stabbing provoke public outrage, despite the fact that the failure to rescue in such circumstances is not illegal. While courts are reluctant to do away with the rule fearing the creation of

an unworkable general duty of beneficence, they have been increasingly willing to recognize exceptions that chip away at the rule. Following in that mode are a group of decisions that reject the notion that treatment is required to establish doctor–patient relationships. These decisions recognize a limited doctor–patient relationship arising out of employment as well as other types of nontherapeutic evaluations performed for the benefit of a third party.

These decisions are carefully confined to their facts. They do not recognize a claim for any harm that would be compensable in a medical malpractice claim, such as an incorrect diagnosis. Rather, these decisions recognize a limited duty to avoid only the following specific harms.

The Duty to Not Cause Harm in the Conduct of an Examination

Many jurisdictions that reject medical malpractice claims by employee/examinees arising out of examinations for the benefit of third parties have recognized a negligence claim when the examiner engages in conduct that causes physical harm to the person being examined (*Greenberg v. Perkins*, 1993). In most of the reported cases this involves subjecting the examinee to a physical test of an injury or impairment that results in harm or dysfunction not present prior to the examination. Examinations that cause harm are disquieting and the claims of those injured have not fallen on deaf ears. “The limited relationship between the examiner and the plaintiff encompasses a duty by the examiner to exercise care consistent with his professional training and expertise so as not to cause physical harm by negligently conducting the examination” (*Harris v. Kreutzer*, 2006, p. 29; see also *Dyer v. Trachtman*, 2004).

Although most of the reported cases involve physical harm, the principle underlying the rule is not restricted by any logic to physical harm. Indeed, in one recent case, a psychologist’s allegedly verbally abusive behavior during an IME of a claimant asserting traumatic brain injury resulting in psychological trauma was recognized as viable. “Because the [IME] functions only to ascertain information relative to the underlying litigation, the physician’s duty in [an IME] is solely to examine the patient without harming her in the conduct of the examination” (*Harris v. Kreutzer*, 2006, p. 31; see also *Martinez v. Lewis*, 1998). Thus, the obligation of the examiner to discover relevant information regarding the subject’s injuries and impairments must be balanced against the obligation not to worsen those injuries or impairments in the process of learning about them.

The Duty to Communicate Critical Information

In addition to a duty to avoid causing harm in the evaluation, a number of states have recognized a duty to report serious new abnormal test results obtained in an evaluation conducted for the benefit of a third party. These cases, like those imposing a duty to examine without causing harm, do not involve a review of the reliability of the evaluation or the failure to discover a condition. Rather

they address the failure to communicate what was discovered. Thus far, no psychiatric or psychological discoveries have been at issue in the reported decisions, but there is nothing in the reasoning of those opinions that would limit their application. Case law has not yet encompassed circumstances in which a disability or disability-related psychiatric or psychological evaluation yielded evidence of suicidal ideation or intent to harm others that was not communicated to appropriate parties and resulted in harm, but such a case is not hard to imagine.

The Duty to Maintain Confidentiality

In writing reports and testifying about the results of an evaluation, psychiatrists and psychologists face a dilemma. Professional ethics require the protection of confidentiality as far as possible in third-party employment evaluations (see Chapter 1). However, the duty to maintain confidentiality is constrained by the need to make disclosures that fulfill the purpose of the evaluation. Therefore, sensitive personal data that are irrelevant to the purpose of an evaluation should be withheld in the interests of privacy and disclosure should be limited in scope and directed only for the purpose for which consent was provided.

For example, in *McGreal v. Ostrow* (2004), Mr. McGreal, a police officer, underwent a fitness-for-duty evaluation. Subsequently, the report was disseminated. Mr. McGreal's psychological evaluation included sensitive personal information not relevant to his fitness for duty and had been disseminated far beyond the superiors responsible for the determination of his fitness and the purposes for which the report was created. Mr. McGreal brought a claim under the state confidentiality act. The trial court dismissed the claim on a motion for summary judgment but the appeals court reversed and remanded. The Illinois Supreme Court held that a police chief had the authority to order fitness-for-duty evaluations of officers in the interest of public safety and that logically the police chief was entitled to the results of the examination. However, the act allowed disclosure only under narrow circumstances and a reasonable doubt existed whether those circumstances were present in this case, implying that the state confidentiality act had to be followed in disseminating the fitness-for-duty report.

Protecting confidentiality by withholding seemingly irrelevant information disclosed by the examinee risks a painful cross-examination that may undermine credibility should litigation arise. Advancing the credibility of the examination by providing all information disclosed to an employer risks unnecessary breaches of confidentiality and psychological harm to the examinee. In some instances specific state privacy laws govern the procedures for disclosure of health information even in the judicial context and may serve as a third category of liability arising out of employment evaluations (*Pettus v. Cole*, 1996). For a discussion of claims that may arise under federal law, see the discussion below regarding privacy and confidentiality.

Breach of Duty and Harm

To prevail in a negligence claim, in addition to proving the existence of a duty, the claimant must also prove that the duty was breached and proximately caused compensable harm. Breach is typically assessed by measuring the defendant's behavior against what the behavior of other members of the profession would be in similar circumstances. This assessment leaves room for debate between experts about other physicians' common practices and the nature of the ordinary skill of practitioners.

In order to establish medical malpractice, it must be shown by a preponderance of evidence that the injury complained of was caused by the doing of some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct and proximate result of such doing or failing to do some one or more of such particular things (*Bruni v. Tatsumi*, 1976, p. 675).

The claimant must also convince the jury that the doctor's breach of duty is causally linked to the harm claimed, that is, that the outcome would have been different and better if the defendant had acted appropriately. If no harm was suffered or if the same harm would have occurred regardless of the breach of duty, for example, where the condition that the defendant negligently failed to diagnose was not curable nor could its course be altered by timely treatment, the causation requirement is not met and the claim fails.

The requirement that compensable harm must be closely linked or proximate to the negligence results from the law's effort to make the financial consequences of negligence proportional to the negligent act. This link is typically expressed in terms of foreseeability of harm within the risk that made the defendant's actions negligent in the first place. For example, where the defendant's care of the patient was negligent giving rise to an increased risk of suicide, but the suicide did not occur until 2 months later when the plaintiff had stopped seeing the defendant and, in the interim, had seen a new psychiatrist, the harm would not be proximate to the defendant psychiatrist's negligence. An act of suicide 2 months after cessation of treatment with the defendant psychiatrist would not be considered a foreseeable risk despite negligent care.

Finally, the law must recognize the harm caused by the breach of duty. Thus, minor hurt feelings or the loss of one night's sleep would not suffice to support a prima facie case of negligence, but major depression or a suicide attempt would. Although the law has long been wary of mental or emotional loss as in claims of damages (e.g., capping intangible loss), at least when unaccompanied by some physical impact or injury, it remains a cognizable albeit problematic damage claim.

Immunity in the Provision of Disability and Disability-Related Evaluations

Most disability and disability-related evaluations are conducted outside the legal arena. Therefore, any type of immunity associated with providing testimony or evaluations to the legal system will not be applicable. Possible causes of action related to third-party evaluations for which no immunity is available include defamation, invasion of privacy, breach of contract, perjury, and other intentional torts. For example, negligent interference with a contractual relationship is a relatively new but developing doctrine that may create liability for third-party evaluations, including mental health professionals (Postol, 2003).

Of possible causes of action other than negligence or malpractice, defamation appears to be the most common. Although mere opinions are not actionable, other types of statements may be. Generally, physicians cannot be sued for defamation for their opinions concerning a worker's ability to work unless the statement made was false and made with recklessness (Postol, 2003).

Notwithstanding the negligence of the defendant, if evaluations or testimony are provided in certain legal circumstances, the law insulates the defendant from liability in order to advance a different agenda. This insulation may apply if the disability or disability-related evaluation is conducted within a litigation context. One way in which the law seeks to encourage witnesses' participation in the judicial system is to provide certain immunities for the benefit of citizens engaged in this community service. "[T]he claims of the individual must yield to the dictates of public policy, which requires that the paths which lead to the ascertainment of truth should be left as free and unobstructed as possible" (*Calkins v. Sumner*, 1860, p. 197).

Thus, the common law has long recognized that witnesses should not be subject to lawsuits for defamation for statements given under oath on the witness stand. "A witness is absolutely privileged to publish defamatory matter concerning another in communications preliminary to a proposed judicial proceeding or as a part of a judicial proceeding in which he is testifying, if it has some relation to the proceeding" (American Law Institute, 1981, p. 588). The rule that witnesses are immune from suits for defamation for their testimony applies to lay and expert witnesses alike.

However, witness immunity is not absolute under all circumstances. Because witness immunity is intended to assist in the administration of justice, it has no application to statements made prior to the commencement of litigation or after commencement but outside the judicial process (*Twelker v. Shannon & Wilson*, 1977). Nor does witness immunity extend beyond the courtroom. For example, the reach of professional disciplinary proceedings to address behavior on the stand (i.e., *Austin v. American Association of Neurological Surgeons*, 2001), as well as criminal proceedings, for example, to face perjury charges (*Riffe v. Armstrong*, 1996) is unaffected by immunity in conjunction with expert testimony.

The discussion of immunity often brings up the terms “witness immunity” and “quasi-judicial immunity.” These labels are used differently by different courts and are a better starting point than ending point in predicting whether immunity will protect an expert providing testimony in disability and disability-related evaluation cases. In general, witness immunity tends to be more qualified or conditional than quasi-judicial immunity. Qualified immunity shields some behaviors, such as good faith mistakes. Quasi-judicial immunity tends to be less qualified and provides a broader shield, even for bad faith actions. The more unqualified the immunity, the more likely a court will dismiss the claim on its face. The more qualified the immunity, the more likely it may require completion of discovery or even taking evidence at trial to determine its application.

At one extreme are cases such as *Bruce v. Byrne-Stevens* (1989) that refuse to limit witness immunity to defamation for court-appointed experts and recognized unqualified immunity for all experts. “[E]nsuring objective, reliable testimony – dictates in favor of immunity for experts.” Many jurisdictions only grant court-appointed experts this sort of immunity under the label quasi-judicial immunity, a reason many psychiatrists and psychologists will only testify if they are court-appointed. But not all jurisdictions recognize quasi-judicial immunity for all court-appointed experts (*Levine v. Wiss*, 1984). For example,

... [Q]uasi-judicial immunity is generally not extended to an examination conducted at the request of one of the parties to the litigation. ... Rather, the cases that recognize quasi-judicial immunity for court-appointed psychiatric examiners do so only when the examiner is appointed by and reports directly to the court. ... In effect, such an appointee acts as an officer of the court (*Dalton v. Miller*, 1999, p. 668).

In any event, since most disability and disability-related evaluations are conducted outside a litigation context, the question of immunity will never arise.

Similarly, a number of states have concluded that experts providing litigation support services are not cloaked with any immunity and are subject to ordinary negligence claims for harm caused by substandard services (*Murphy v. A.A. Matthews*, 1992). These cases have involved conduct such as incorrectly advising that a malpractice claim would not be recognized and incorrectly calculating damages that resulted in agreeing to a reduced settlement. Thus far, psychiatrists and psychologists are not well represented in reported decisions regarding immunity from suit for expert testimony, but the relevant cases do not appear to draw distinctions that would change the result for them.

Privacy and Confidentiality: Access to Information

In a traditional doctor–patient relationship, the subject of an evaluation is the intended recipient of information gained. In contrast, disability and disability-related evaluations are generally conducted for the express purpose of providing information to the third party who contracts for the evaluation.

Outside of litigation, mental health professionals have commonly assumed that they owe a duty to provide the information gained in a third-party evaluation to the party who retained their services and no one else. Evaluatees who request voluntary disclosure of that information from the evaluator are generally referred to the third party who contracted for the evaluation and who could choose to disclose or not.

However, the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule gives patients the right to inspect and copy their records. Clinicians who meet HIPAA's definition of a health-care provider must comply with the Privacy Rule's requirements for disclosure of protected health information (PHI). HIPAA's Privacy Rule defines PHI as all "individually identifiable health information held or transmitted by a covered entity or its business associates, in any form or media, whether electronic, paper or oral" (45 CFR §160.103). This definition does not distinguish information generated by employment-related mental health evaluations from records of treatment. Nor does the Privacy Rule explicitly make the purpose for which the information was created of any consequence (Gold & Metzner, 2006).

The Office of Civil Rights is responsible for enforcing HIPAA regulations. This office reports the case of a private medical practice that denied an individual access to medical records of the individual's IME at the direction of the retaining insurance company. The Office of Civil Rights states that it required the practice to revise its policies and procedures regarding access to "reflect the individual's right of access regardless of payment source" (United States Department of Health and Human Resources, Office of Civil Rights-HIPAA, 2007).

The Social Security Administration (SSA) takes the position that a purely diagnostic consultative examination (CE) (see Chapter 7) performed by a health-care professional for SSA disability purposes is a covered health-care function (45 CFR §164.501) requiring compliance with the Privacy Rule (Health and Human Services Summary of the HIPAA Privacy Rule, 2006). However, in contrast to the ruling of the Office of Compliance and Enforcement, SSA advises consultative examiners that requests for the report of a CE should be directed to the state disability determination service (Social Security Administration, 2006). To date, no opinions have addressed whether this is an apparent or actual conflict.

HIPAA's regulations permit a patient to authorize disclosure but require that the authorization be in writing, signed by the patient or the patient's legal representative, describe what is to be disclosed, to whom, the purpose of disclosure, include an expiration date and an explicit acknowledgment of a broad array of rights (45 CFR §154.508). They also require that the healthcare provider keep a record of all disclosures (45 CFR §164.512(e)). The Privacy Rule does authorize disclosure without patient authorization in specified cases. For example, the Privacy Rule specifically states that it is "not intended to disrupt existing workers' compensation systems as established by State law. . . . To this end, the Privacy Rule explicitly permits a covered entity to disclose protected health information as authorized by, and to the extent necessary to

comply with workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness..." (45 CFR §164.512(j)).

Similarly, in a judicial or administrative proceeding, PHI may be disclosed without authorization pursuant to an order from the court or administrative tribunal or pursuant to a discovery request or subpoena, provided it is accompanied by an assurance that the subject of the records has been notified or reasonable efforts will be made to give notice of the request, or that reasonable efforts have been made to secure a qualified protective order limiting access to these records (*Bayne v. Provost*, 2005; 45 CFR §164.512(e)). Without these assurances or the signature of a judge, a subpoena or discovery request does not authorize disclosure. HIPAA requires a formal authorization to conduct an ex parte interview (i.e., without the presence of the opposing party) of health-care and medical personnel employed by an opposing party (see *Keshecki v. St. Vincent's Medical Center*, 2004).

In the case of conflicting requirements, one method HIPAA adopts for resolving potential conflicts between state and federal law is by requiring compliance with the law that imposes the most stringent privacy protection. Thus, HIPAA creates a minimum standard for privacy and confidentiality, which may be superseded by more stringent state laws. Another method of avoiding conflicts is by excluding certain areas of state law, such as workers' compensation (as discussed above), from HIPAA preemption.

Although disclosure of PHI to the patient/evaluee is designated as mandatory, exceptions to the right of access to personal records exist, and HIPAA specifically delineates grounds for denying access. Some of these denials may be appealed for review, others may not, again as per HIPAA regulations. For example, patients may be denied access to psychotherapy notes and are not entitled to review of this denial. Patients may also be denied access to their records if it is thought likely to endanger the patient or others, but this denial may be appealed and reviewed.

However, none of the grounds for denial of access, whether subject to appeal or not, are based on the fact that the documents were created for purposes of a third-party evaluation or were paid for by a party other than the evaluatee, nor are they related to the nature of the physician-patient relationship. A psychiatrist or psychologist who is a covered entity under HIPAA conducting IMEs, disability, or disability-related evaluations, or third-party evaluations should therefore include in their initial disclosures to evaluatees the relevant aspects of the Privacy Rule as well as their practices regarding obtaining reports. Finally, mental health professionals should be aware that the Privacy Rule requires covered psychiatrists and psychologists to maintain a log of all PHI disclosures.

One major exception made by HIPAA to the patient's right of access to their records which may be relevant to disability and disability-related evaluations is the limitation of disclosure of information "compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding" (45 CFR §164.529). An examination by an expert retained after litigation has

begun is cloaked by work product and does not lose that protection under HIPAA. Mental health professionals should bear in mind, however, that since most of the employment examinations occur outside litigation, work product protection would not apply.

Nevertheless, if litigation ensues, evaluatees will typically obtain copies of disability and disability-related evaluations through the discovery process. When litigation is threatened or pending, it should be assumed that the author of any relevant document may be confronted with it on cross-examination. As should be standard practice, psychiatrists and psychologists should be certain that reports and disclosures adhere to professional, ethical, and legal standards.

Qualitative Standards for Employment Evaluations

Psychiatric and Psychological Evaluations Intended for Judicial Consumption

Although most evaluations are conducted outside the courts and never find their way there, some do. Some disability and disability-related evaluations conducted without any thought of judicial oversight arrive in court when the subject of the evaluation challenges a decision based on the mental health professional's opinions or report. Some examinations may be conducted explicitly to support a decision that has proceeded through administrative or company procedures and is now being challenged in a civil lawsuit.

However factually and/or technically complex the dispute the parties bring to court may be, jurors are not chosen because of their expertise or familiarity with the case. Indeed, specialized knowledge about a case acquired outside of the parties' evidentiary presentation in that case may result in juror disqualification. It follows that because of the purposeful limitations on the knowledge and skills of the jury, some minimum threshold will be necessary to prevent jurors (and judges as well) from relying upon superficially attractive but patently false claims of expertise.

Until the early twentieth century, courts relied solely on the qualifications of a proffered expert, the opportunity for cross-examination, and presentation of opposing experts to assure that jurors sensibly scrutinized claims of expertise. The D.C. Court of Appeals decision in *Frye v. United States* (1923) played a seminal role in changing exclusive reliance on qualifications for admission of expert evidence. After recognizing a distinction between the qualifications of an expert and the reliability of the science upon which the expert relies, *Frye* articulated a standard for determining the reliability of the science. According to *Frye*, courts should apply a "general acceptance" in the relevant professional communities as the standard for scientific reliability.

In using “general acceptance” as a proxy for scientific accuracy, *Frye* raised a host of new problems about who must accept, what must be accepted, as well as what constitutes general acceptance. In the midst of *Frye*’s increased application and criticism, the Federal Rules of Evidence (FRE) were codified in 1975 with no references to *Frye*. It was not until 1993 that the Supreme Court resolved *Frye*’s survival under the FRE in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* The Court found no reference to *Frye* in the FRE and concluded that *Frye* was not intended to be the benchmark for scientific testimony under the FRE.

The Court focused on Karl Popper’s work on falsifiability in science as a guide to what constitutes scientific knowledge. It articulated four factors bearing on reliability for federal trial courts to consider in the admission of scientific experts under the FRE: whether the experts’ methods and procedures were testable and had been tested; whether it had been subjected to peer review and publication; if so what was the error rate and could it be controlled; and finally a rebirth of *Frye*’s general acceptance test. Two subsequent decisions, *General Electric v. Joiner* (1997) and *Kumho Tire Co. v. Carmichael* (1999), clarified that these considerations applied to the admissibility of all experts. The *Daubert* analysis is at the discretion of the trial court who might apply some of these criteria but not others, or other criteria not articulated by the Court, depending on the nature of the case.

Although the vocabulary may have changed, for the most part, *Daubert* has not resulted in a sea change for most psychiatric and psychological experts. Clinical opinion testimony remains the most common psychiatric and psychological forensic contribution, as well as the most vulnerable to scientific critique (Shuman & Sales, 1998). Nevertheless, the most compelling argument for an expert to embrace *Daubert*’s preference for the use of techniques which have been validated in studies published in peer-reviewed journals is that if a laissez-faire trial court is suddenly moved to apply *Daubert* strictly, it will be too late for the unsuspecting expert to do much about it (Shuman & Sales, 2001).

Like “Pascal’s Wager,” designed to demonstrate why the smart money was on a belief in God, “*Daubert*’s Wager” is intended to demonstrate why smart experts will assume that their testimony will have to meet a *Daubert* threshold (Shuman & Sales, 2001). Even though no lawsuit may be in sight when a disability or disability-related evaluation takes place, litigation is always a possibility and evaluations, which may become testimony, should therefore be conducted accordingly. Adhering to *Daubert* standards is also prudent because even if *Daubert* issues are not pursued as a matter of admissibility or legal competence, they may appear on cross-examination, where they will speak to the weight or credibility of the expert’s testimony.

Psychiatric and Psychological Evaluations Intended for Administrative Consumption

Most disability and disability-related disputes decided by a third party are not heard in court but rather by administrative tribunals, such as the Equal

Employment Opportunity Commission, the SSA, and state workers' compensation boards. *Daubert*, interpreting the FRE, has no relevance for the vast majority of administrative law determinations (*Pasha v. Gonzales*, 2005). By their own terms, the FRE apply only in trials in the federal district courts (Fed. R. Evid. 1101), not in administrative hearings (*Dubose v. USDA*, 1983).

Evidentiary decision making by federal agencies is governed by 280 different regulations. Most agencies have a single evidentiary regulation applicable to all adjudications, but some distinguish among proceedings of different types or conducted under different statutes. Agency evidentiary regulations differ considerably in their precise language but they can be divided initially into two general categories. The majority, 243 of 280, makes no reference to the FRE and appear not to impose any constraints on the discretion of administrative law judges (ALJs) in regard to the admission of evidence. Often these provisions either parrot the Administrative Procedure Act (2006), which governs procedures for agency determinations, or paraphrase it. The other 37 evidentiary regulations make some reference to the FRE (Pierce, 1987).

Administrative proceedings before the SSA and Equal Employment Opportunity Commission (EEOC), for example, are heard by ALJs who are experienced attorneys and are governed by the Administrative Procedure Act. The Act provides that "any oral or documentary evidence may be received, but every agency shall as a matter of policy provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence." Whatever rules are applied under federal as well as state law, admissibility at an administrative hearing is committed to the discretion of the ALJ, which means that the judge's decision is unlikely to be reversed (*Bar-Av v. Psychology Examining Bd.*, 2007).

The threshold for admissibility in proceedings under the Administrative Procedure Act is reliability. "[B]ecause an ALJ's findings must be supported by substantial evidence, an ALJ may depend upon expert testimony only if the testimony is reliable" (*McKinnie v. Barnhart*, 2004, p. 910). Reliable expert testimony in this context is characterized by four considerations. It should:

1. rest on an adequate basis (i.e., dates and details of interviews and examinations; results of appropriate laboratory and psychological testing; school, military, and work records);
2. clearly articulate what opinion(s) or conclusion the expert draws from the raw data;
3. clearly explain how the expert reasoned from the raw data to the opinion offered, including the relevant science and its limits; and
4. fairly address these issues from the opponent's perspective (*Gilbert v. DaimlerChrysler Corp.*, 2004; Shuman, 2005).

Conclusion

Psychiatric and psychological disability and disability-related evaluations performed for the benefit of a third party may be common, but relying solely on common sense or clinical intuition to ascertain the difference in legal obligations between workplace evaluations and traditional psychiatrist/psychologist–patient relationships is not advisable. Although many of the legal obligations overlap ethical obligations, these two sets of obligations are not entirely congruent. Mental health professionals conducting disability and disability-related evaluations should be familiar with the necessary clinical skills, ethical obligations, and legal duties required to provide competent, reliable evaluations.

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