

THE STATE OF NEW HAMPSHIRE

SUPREME COURT

No. 2007-0102

**Shelby Baxter, a minor, By her Mother and Next Friend
Patricia Baxter**

v.

Charles Temple & a.,

**AMICUS BRIEF ON BEHALF OF THE
AMERICAN ACADEMY CLINICAL NEUROPSYCHOLOGY**

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American Psychologist, Psychological Testing and Psychological Assessment: A Review of Evidence and Issues., 56, 128-165, Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., Eisman, E. J., Kubiszyn, T. W., & Reed, G. M. (2001)

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STATEMENT OF INTEREST OF THE AMICUS CURIAE

The American Academy of Clinical Neuropsychology (hereinafter AACN) is the membership organization of clinical neuropsychologists who are board certified under the auspices of the American Board of Professional Psychology. Clinical neuropsychology is the practice domain of licensed clinical psychologists who have specialized in evaluating and treating individuals who are known or suspected to have brain dysfunction.

The AACN through its Board of Directors (hereinafter “we”) wishes to provide information relevant to two key issues found in the Superior Court Order on Defendant’s Fourth Motion in Limine, in the case of Shelby Baxter and Patricia Baxter v. Charles Temple and Kelly Temple, No. 01-C-0567. We offer this Amicus with no intention of addressing either the merits of the case at hand, or the merits of the substantive opinions expressed by any expert in the case regarding the plaintiff’s claims. Our intent is solely to address two key issues raised by Presiding Justice Philip Hollman in the August 2005 Order on Defendant’s Fourth Motion in Limine. These issues pertain to (1) the scientific merits and acceptability of the flexible battery approach in clinical neuropsychology, and (2) the contention that the threshold for clinical judgments of clinical neuropsychologists is lesser than for forensic judgments, i.e., data-based clinical judgments do not meet legal admissibility standards.

All practicing clinical neuropsychologists have an interest in how psychology in any jurisdiction is practiced due to the potential impact on the field as a whole. The adverse effects of suppressing valid neuropsychological test data simply because it is customarily grouped under the term “flexible battery” will not be contained by the imaginary border of this Court’s

jurisdiction. The impact could extend and be widely felt throughout the field (e.g., psychologists may avoid valid neuropsychological tests with clinical patients due to fear that a clinical case could become the subject of future litigation). Moreover, psychologists in the United States are held to the same code of ethical standards no matter where they practice: when conduct that may conflict with those standards occurs in any one locale it is of concern to all psychologists regardless of their practicing jurisdiction.

QUESTIONS PRESENTED FOR REVIEW

See Notice of Appeal.

CONSTITUTIONAL PROVISIONS AT ISSUE IN THIS CASE

Not applicable.

STATUTORY PROVISIONS AT ISSUE IN THIS CASE

NEW HAMPSHIRE RULES OF EVIDENCE

Rule 702. Testimony by Experts

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

Rule 703. Bases of Opinion Testimony by Experts

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

FACTS AND STATEMENT OF THE CASE

See Plaintiff's Brief

SUMMARY OF ARGUMENT

Reliance on a flexible battery approach to neuropsychological testing is empirically proven as a mainstream practice. The logic of the flexible-battery approach is the same as in clinical medicine, namely, selection of different test groupings because of the many forms that brain damage can take; No single “fixed” battery can address every issue or question that arises. There is no such thing as a “fixed medical battery” given to all medical patients regardless of history, yet medical procedures, even when vaguely defined as “history and physical” are regularly admitted into court.

Test validity lies in individual tests, not test batteries as a whole. On a separate issue, there is no fundamental difference in the respective roles of clinical versus forensic neuropsychologists. Both roles rely on the same scientific methods for validating individual tests to answer specific questions. As an example, there is no different standard of scientific proof for tests measuring memory loss in the Alzheimer’s patient versus a test for competency to stand trial. Neuropsychologists in both roles strive for objectivity and accuracy.

The idea that clinical decision making is no more than “guesswork” and that “forensic decision making” is intellectually superior, is not valid.

The opinions of a clinical neuropsychologist can assist the trier-of-fact.

ARGUMENT

I. Neuropsychology Utilizes Three Assessment Approaches

As the field of clinical neuropsychology has developed, there have been three well-defined primary assessment approaches that have constituted the primary training and practice models for the field. The definitions of these approaches are commonly understood by trainers and practitioners in the field. In all three assessment approaches, clinical neuropsychologists are expected to select and rely on standardized tests that have been the subject of peer-reviewed scientific investigation and have been found to be reliable and valid for the applications in the specific case. These assessment approaches are:

A. Definitions

The **standardized battery (a/k/a “fixed battery”)** approach refers to an invariant grouping of tests that is routinely administered to individuals regardless of diagnosis, clinical history, social history, age, or referral question. To illustrate, if the “fixed battery” approach were used, then a middle-aged person with an irradiated brain tumor seeking job reinstatement would get the same fixed test battery as an elderly dementing person whose competency to stand trial is at issue.

The **flexible approach** represents a position that is opposed to the standardized battery approach in that test selection is based upon the individual needs of the patient and is not uniform, even with patients who have the same neurological disorder. This approach is also more likely to engender use of non-standardized test administration procedures, which is much less likely to occur in the standardized battery or flexible battery approaches.

The **flexible battery approach** consists of a core test battery specific to a known or suspected disorder, with the core batteries differing across suspected disorders. For example, a clinician would use the same core battery for patients with possible Alzheimer's disease, but a different battery for a young adult with suspected attention-deficit hyperactivity disorder.

II. The Flexible Battery Approach Is Generally Accepted

The flexible battery approach is a generally accepted practice in mainstream neuropsychological practice. Moreover, test validity lies in individual tests, not in "test batteries". The flexible battery approach is very similar in structure, scientific merits, and logic to diagnostic testing in clinical medicine. There is no such thing as a "fixed medical test battery," yet medical procedures regularly found to be reliable enough to earn legal admissibility.

Clinical neuropsychology in the United States and Canada historically grew out of the standardized ("fixed") battery approach for conceptual reasons. It has been erroneously believed that all brain damaged individuals were alike in a single fundamental way, termed "organicity." Hence, only a single test or test battery was necessary to capture "organicity." But advances in clinical medicine and neurology showed that different brain diseases affected persons in different ways, necessitating a greater role for clinical judgment in test selection. Hence, the standardized battery approach now holds primarily historical interest.

As formal professional practice surveys of the field have demonstrated in clear and compelling fashion, the flexible battery approach is now the dominant approach, while standardized batteries are used by an increasingly smaller minority of clinicians. See The

Clinical Psychologist, 20 at 333 (2006). The graph at Figure 1 of the aforementioned article (reproduced below)

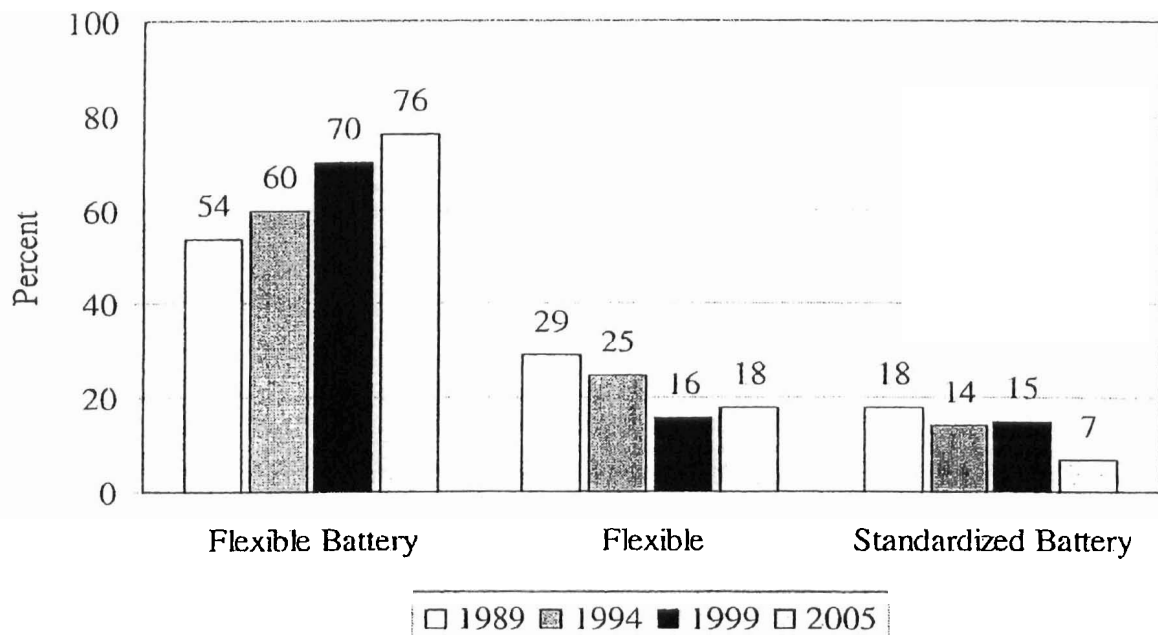


Figure 1 Primary philosophical approach toward test selection. *Note.* “Flexible Battery” = variable but routine groups of tests for different types of patients, such as head injury, alcoholism, elderly, etc.; “Flexible” = based upon the needs of an individual case, not uniform across patients; “Standardized Battery” = routine group of tests uniform across patients such as the Halstead-Reitan, Luria-Nebraska, Benton, or other standard battery.

Philosophical Approach toward Test Selection

Figure 1 demonstrates the historical and current viewpoint of clinical neuropsychologists regarding their approach toward test selection. Quite apparent in the chronological survey data is the trend from 1989 to 2005 for more individuals to align with the flexible battery approach, to the point that 3 of 4 currently identify with this philosophical position. In contrast, proponents of the standardized battery approach have continued to decrease proportionally, currently accounting for only 7% of clinical neuropsychologists.

depicts the results of four professional practice surveys in which large representative samples of clinical neuropsychologists were asked to choose the assessment approach that best described their method of assessing patients referred for formal neuropsychological testing. Id.

The survey graph and accompanying paragraph, supra, are the result of a large survey that was sponsored by the AACN, subjected to extensive peer review, and was published in the AACN official journal, *The Clinical Neuropsychologist*. (A copy of the article is provided in the Appendix to the Amicus Brief)

There are many additional reasons that the field of clinical neuropsychology has rejected the notion that a rigid, fixed battery should be administered to any and all patients in order to answer all possible referral questions. A primary reason is that for decades, clinical research into standardized one size fits all test batteries has been absent in the most widely read and peer-reviewed journals in clinical neuropsychology. Peer reviewed clinical research has either focused on how numerous individual tools address a particular deficit, or disorder-specific batteries reflective of the flexible-battery approach. Because of research that studies individual tests rather than a fixed battery, we now have a much better understanding of the neuropsychological effects of specific brain disorders. This understanding has led to the logical conclusion that administering the same set of tests to all patients and litigants regardless of the known or suspected condition is uninformed and inappropriate practice.

For example, a competent clinical neuropsychologist would not give the same test battery to an 80-year-old patient with probable Alzheimer's disease and an 18-year-old student referred for possible attention-deficit hyperactivity disorder. The former requires more memory tests be given, while the latter more tests of various types of attentional processes. There is no single standardized (fixed) battery of tests appropriate to both populations. Similarly, were we

considering the question of whether there is a standard “legal competency” battery, there is no single ‘one size fits all’ test battery for legal decision-making; criminal responsibility, testamentary competence, and competency to stand trial require different tests.

The notion that a rigid, invariant battery can respond to all clinical concerns is a specious argument with no clinical or scientific merit. An example from medicine is illustrative. The specialty within medicine that most closely parallels clinical neuropsychology is that of clinical neurology. Neurologists are trained to rely upon (a) physical and mental status exam procedures, which neurologists conduct with their patients, and (b) diagnostic tests (e.g., CT and MRI brain scans, functional neuroimaging, electroencephalogram, blood tests, etc.), which they can order and are conducted by other trained specialists on their patients. In a parallel to the widespread practices of neuropsychologists, neurologists choose not to conduct either an invariant exam procedure or order an invariant set of diagnostic tests for each and every patient. Instead, exam procedures and diagnostic tests are chosen based upon the clinical condition of the patient that is suspected or known.

Neurological examination procedures and diagnostic tests have reliability and validity individually that has been established in peer-reviewed scientific investigations.

There is no expectation that the specific *battery* of neurological exam procedures and diagnostic tests chosen by the neurologist be studied as a whole with regard to validity. In other words, a standardized battery approach runs counter to an acceptable standard of care in neurology. In fact, we know of no area of specialty or sub-specialty of clinical medicine in which a routine, invariant battery of tests (i.e., a standardized battery) across all medical conditions being evaluated would be acceptable practice. Instead, medical specialties have the equivalent of flexible batteries of physical examination and diagnostic test procedures that are

expected to be given, depending upon the clinical condition that is known or suspected.

The assessment approach of clinical neuropsychology has simply evolved as a more mature field has broadened its clinical research and its understanding of the best methodology to evaluate patients, wherein it is no longer appropriate to use the only tool in the toolbox on all patients. In doing so, clinical neuropsychology has matured in a manner quite comparable to the medical specialties that preceded it.

We note in a hallmark article in *The American Psychologist* (the flagship journal published by the American Psychological Association) authored by numerous prominent assessment experts summarized the status of psychological and neuropsychological assessment as compared to medical tests. *American Psychologist*, 56 at 128-165 (2001). The authors state that “habitual testing of all patients using large fixed batteries” is a questionable practice. *Id.* at 129. Instead, the authors, after presenting a large scale analysis of individual tests, note among their recommendations that a group of patients deemed to be in need of psychological assessment could be provided with “...a flexible, multimethod assessment battery using tests typically employed in practice and selected on the basis of idiographic referral questions by a clinician competent in the relevant domain...”. *Id.* at 154. This viewpoint of these authors fits exactly with the predominant view of clinicians in neuropsychology. (A copy of the article is provided in the Appendix to the Amicus Brief)

III. There is No Relevant Distinction Between The Assessments Performed by A Forensic or Clinical Neuropsychologist

Page 11 of the Superior Court’s Order refers to an opinion expressed by Dr. Faust that

the use of a combination of tests by Dr. Bruno-Golden that does not represent a standardized battery is equivalent to “a guessing game”, which is acceptable in a clinical context, but not in a forensic context. Later, on page 12, Dr. Faust is quoted as indicating that the goal of a neuropsychologist in a clinical role is to advance the patient’s interest, whereas the forensic neuropsychologist is to provide objective analysis. We believe that these two related opinions are inaccurate.

First, the scientific literature does not express itself in this manner. Either the individual tests selected for inclusion in a flexible-battery are scientifically valid or they are not. Specifically, either Dr. Bruno-Golden selected individual tests that are well validated and then used them correctly or she did not. It is not part of scientific hypothesis testing to determine an outcome of whether a test can be applied in a forensic context or not. If a test is not scientifically well validated, it would not be appropriate for use in a clinical or a forensic context.

Second, despite the beliefs of Defendants’ psychology expert, the clinical and “forensic” neuropsychologist are not distinguishable by their testing approach, by the scientific merits of their instruments, by balance of objectivity versus subjectivity, by standards of logical proof, or by training. Both the clinical and forensic neuropsychologists rely on situation-specific test batteries, and both strive to be objective and accurate in their characterization of an examinee’s cognitive status. The two are sometimes distinguished only by the form that conclusions take: the clinician answers referral questions and the forensic specialist answers legal questions. Both neuropsychology roles still require scientific validation, but not fundamentally different kinds of scientific validation. A cognitive test of competency to stand trial and a cognitive test of mental changes associated with damage to the frontal lobe of the brain undergo the same validation process with the same standards of scientific proof. There is no lesser threshold for objectivity

or accuracy in a clinical context compared to a forensic context for clinical neuropsychologists.

IV. An Assessment By A Clinical Neuropsychologist Can Assist The Trier-of-Fact

Rule 702 of the Rules of Evidence allows testimony by someone with a “specialized knowledge” base who will assist the trier-of-fact in either one of two basic ways: (a) to understand the evidence, or (b) to determine a fact at issue. The specialized knowledge base of competent clinical neuropsychologists includes training in the administration, scoring, and interpretation of, and research into, individual neuropsychological tests. Regarding element (a), the clinical neuropsychologist can, among other contributions, provide definitions of neuropsychological testing, discuss cognitive test development, or summarize functional organization of the brain. Regarding element (b), a fact at issue could be the permanency (or lack thereof) and extent of cognitive deficits in the plaintiff. A clinical neuropsychologist can likewise provide assistance in making such determinations.

CONCLUSION

Neuropsychology, like clinical medicine, combines objective testing methods with subjective interpretation to draw a best-fitting conclusion. Neuropsychology, like clinical medicine, requires the selection of individually validated diagnostic tests. These tests must be harmonized with the patient's presentation and referral question.

There is no such thing as a "standardized" or "fixed" battery suitable for all questions or presentations, whether the clinician is a neuropsychologist or a physician. The scientific methods of neuropsychologists who primarily perform clinical work and those who primarily perform forensic work do not differ fundamentally. Though clinical and forensic referral questions may differ, they often overlap. The legal question "Are there compensable damages related to the accident at issue?" overlaps greatly with the clinical question "Are there residual cognitive defects as a result of the head injury?"

Neuropsychologists can help the trier-of-fact answer these questions in a reasonably certain and scientifically-sound manner, just as most physicians can when the issues fall within their area of expertise. There are no major distinctions between forensic and clinical methods.

Submitted on behalf of the membership of the American Academy of Clinical
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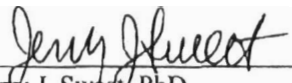
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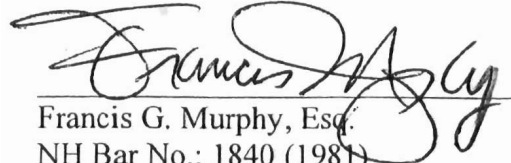
Respectfully Submitted,

AMERICAN ACADEMY
CLINICAL NEUROPSYCHOLOGY

By its attorneys
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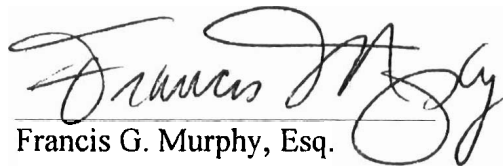
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Certification of Service

I hereby certify that an original and eight (8) copies of this Brief have been this day been delivered to the Clerk of the Supreme Court; that two copies of this Brief has been sent by first class mail to Gary M. Burt, Esq., counsel for the Appellee and one copy of this Brief has been sent by first class mail to Christopher Seufert, Esq., and Neil Leifer, Esq., counsel for the Appellant. I further certify that Supreme Court Rules 26(2) and (3) have been complied with.



Francis G. Murphy, Esq.