



**REPORT OF JONATHAN DERIGHT, PHD, ABPP-CN**

**Case Reference:** *In re Complaint No. 23-90015*

**Date of Report:** January 27, 2025

**INTRODUCTION**

In the Spring of 2023, a proceeding began to investigate whether Judge Pauline Newman—a then 96-year-old judge—was mentally fit to perform the duties of her office in response to mounting concerns that she may have been experiencing significant cognitive problems. A Special Committee was appointed to investigate the matter. The Special Committee found evidence that, in their opinion, provided a reasonable basis to indicate that Judge Newman may suffer from a disability that made her unable to discharge the duties of her office. The Special Committee directed Judge Newman to undergo neurological and neuropsychological testing, which Judge Newman declined. On the recommendation of the Special Committee, Judge Newman was suspended from hearing cases for a period of one year. In September 2024, the suspension was renewed for a period of one year. Subsequently, on September 25, 2024, Judge Newman submitted a motion for reconsideration. That motion was primarily based upon the report of Dr. Aaron Filler dated 08/24/2024. Dr. Filler concluded that Judge Newman’s physical and neurologic exams were “entirely normal,” that a Perfusion CT scan “rules out all of the known causes of MCI...and any dementias,” and that there was “no material concern that requires further medical testing.”

I have reviewed Dr. Filler’s report, and it is my opinion that:

1. Dr. Filler’s opinion was not based on standard, reliable, and accepted methods to diagnose cognitive impairment
2. Dr. Filler’s examination did not address all possible causes of cognitive impairment
3. Dr. Filler’s conclusion that no further testing was needed was premature and did not give proper weight to obvious signs of possible impairment in the materials gathered by the Special Committee

I also reviewed several affidavits and declarations that highlighted concerning signs of possible cognitive decline that warrant further comprehensive investigation with validated methodologies. It is my opinion that examinations by Dr. Rothstein and Dr. Carney did not comprehensively address Judge Newman’s cognitive abilities in a manner consistent with standards in the field. Specifically, relying solely upon cognitive screening measures (e.g., the MoCA and the 3-MS) to evaluate fitness for duty in a person with the significant responsibilities of a federal judge is prone to false-negative errors, contrary to scientific guidance, and lacks the psychometric sophistication to determine whether Judge Newman is suffering from cognitive impairment.

### SUMMARY of EXPERT QUALIFICATIONS

I am a clinical psychologist licensed in Virginia, Maryland, and Washington, DC. I am also a diplomate (i.e., Board Certified) in the specialty of Clinical Neuropsychology from the American Board of Professional Psychology. I am a clinical supervisor for clinical psychology graduate students at the George Washington University. I am an approved forensic examiner for competency to stand trial and mental sanity evaluations in the Commonwealth of Virginia, and I am also a member of the Forensic Evaluation Oversight Panel for the Commonwealth. Further, I am a qualified Baseline Assessment Program (BAP) provider for the NFL Concussion Settlement Program and an approved evaluator for the NCAA Concussion Medical Benefits Settlement Program.

I work as a clinical and forensic neuropsychologist in independent practice. In my role, I routinely evaluate patients with a broad array of mental health conditions (both cognitive and psychiatric in nature) to determine their diagnosis, recommendations for treatment, and, when applicable, the manifestation of their condition in various legal contexts. This includes fitness for duty evaluations for physicians, attorneys, and other professionals involving cognitive and psychiatric symptoms, independent medical evaluations for disability and workers' compensation, preemployment evaluations, and evaluations to maintain security clearance. I have been qualified as an expert in various state and federal courts in a retained and court-ordered capacity.

I have delivered trainings in clinical and forensic neuropsychology to judges, attorneys, and mental health professionals. Most relevant to the present report, I have been a panel member for numerous presentations related to the aging legal profession presented to the National Conference for Lawyer Assistance Programs, the DC Bar, and District of Columbia Superior Court Judges. The purpose of these presentations was to highlight the growing challenges facing the aging legal community and how to address concerns about cognitive problems procedurally in a fair and effective manner. I have no personal, professional, or business experience with Judge Newman or any others involved in this matter.<sup>1,2</sup>

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<sup>1</sup> In conducting a fitness for duty evaluation, it is recommended that the examiner not have any prior relationship with the party being evaluated. “[A] mental health FFD evaluator should not have had a previous personal, social, or business relationship with the employee or the employer. Such relationships may also interfere with the evaluator’s ability to conduct a thorough, proper, or independent evaluation.”

Wettstein, R. M. (2013). Fitness-for-duty evaluations. In L. H. Gold & D. L. Vanderpool (Eds.), *Clinical Guide to Mental Disability Evaluations* (pp. 309–336). Springer Science + Business Media. [https://doi.org/10.1007/978-1-4614-5447-2\\_12](https://doi.org/10.1007/978-1-4614-5447-2_12)

<sup>2</sup> When agreeing to perform a fitness for duty evaluation, a clinician should identify the relevant clinical and forensic questions, determine whether that question is within his or her area of expertise, ensure that they can be impartial, and know the relevant standards, rights, and disclosure rules.

Corey, D. M. (2011). 13 Principles of Fitness-for-Duty Evaluations for Police Psychologists. In Jack Kitaeff (Ed.), *Handbook of Police Psychology* (p. 263). Routledge.



## REPORT OUTLINE

This report is based on my review of materials listed in Appendix A.

### SECTION 1: ANALYSIS OF DR. FILLER'S REPORT AND OPINIONS

- *Section 1.1:* Dr. Filler did not perform a comprehensive evaluation consistent with standard practice in assessing cognitive impairment.
- *Section 1.2:* Dr. Filler's opinion that Judge Newman's Perfusion CT scan "rules out all of the known causes of MCI...and any dementias" is not based on a method that has widespread acceptance within the relevant scientific community.
- *Section 1.3:* A "normal" Perfusion CT scan does not obviate the need for generally accepted and objective neuropsychological testing.
- *Section 1.4:* Dr. Filler mischaracterized neuropsychological testing as a subjective means of evaluating a patient.
- *Section 1.5:* There are official criteria and guidelines used to diagnose cognitive impairment, and they do not involve simply administering a Perfusion CT scan.
- *Section 1.6:* Dr. Filler's opinion about Judge Newman's abilities based on a comparison of her activity during his oral arguments in front of her in 2019 and 2022 and his interview of her in 2024 is highly subjective, unscientific, and unreliable.
- *Section 1.7:* Dr. Filler's opinion that there was "no material concern that requires further medical testing" was not based on a comprehensive evaluation and ignores common and obvious signs of possible impairment provided in the materials he reviewed.
- *Section 1.8:* Assessing potential cognitive impairment in the workplace requires a comprehensive approach that is tailored to the needs of a job.

### SECTION 2: ANALYSIS OF ADDITIONAL MATERIALS

- *Section 2.1:* The provided affidavits and declarations highlight concerning signs of possible cognitive decline that warrant further comprehensive investigation with validated methodologies.
- *Section 2.2:* Dr. Rothstein's report does not effectively rule out the presence of possible cognitive decline.
- *Section 2.3:* Dr. Carney's report does not effectively rule out the presence of possible cognitive decline.

### SECTION 3: CONCLUSIONS AND OPINIONS

- *Section 3.1:* The evidence and opinions put forth by Drs. Filler, Rothstein, and Carney were not consistent with standard practice in addressing possible cognitive impairment in a fitness for duty evaluation, and conclusions from these exams indicating that Judge Newman is not in need of further evaluation are not supported.

## SECTION 1: ANALYSIS OF DR. FILLER'S REPORT AND OPINIONS

Dr. Filler, a neurosurgeon and attorney, authored a report dated 08/24/2024.<sup>3</sup> Dr. Filler stated that he volunteered to evaluate Judge Newman and that he has previous experience arguing cases in front of her. Dr. Filler stated that he based his opinion on a review of records, a Perfusion Computed Tomography (Perfusion CT) scan, a “full neurological evaluation”<sup>4</sup> of Judge Newman, and an analysis of Judge Newman’s “verbal and analytical abilities”<sup>5</sup> based on his prior interactions with her as an attorney in 2019 and 2022. In sum, Dr. Filler stated, “I believe that the relevant judicial evaluators should conclude that the components of this report can and do meaningfully and relevantly show that Judge Newman does not suffer from any dementia or detectable decline in intellectual function and that the Judicial Council’s request for medical evaluation of the Hon. Pauline Newman has now been sufficiently completed.”<sup>6</sup>

More specifically, Dr. Filler offered the following opinions<sup>7</sup>:

- 1) “Judge Newman’s general physical exam and neurologic exam was entirely normal” from a cognitive perspective;
- 2) Judge Newman’s Perfusion CT scan “showed an entirely normal blood flow function and anatomy,” which “rules out all of the known causes of MCI (mild cognitive impairment) and any dementias”;
- 3) Judge Newman’s Perfusion CT test results obviate any need for a neuropsychology test battery;
- 4) that “there is no evidence of any mild cognitive impairment, dementia or other mental deterioration” based on his analysis of her actions in his own oral arguments in front of her in 2019 and 2022; and
- 5) that there is “no material concern that requires further medical testing.”

After reviewing Dr. Filler’s report and other information highlighted in Appendix A, it is my opinion that Dr. Filler’s evaluation of Judge Newman did not adhere to standard practices in the field for diagnosing cognitive impairment, and the methods that he did use lack comprehensiveness and scientific credibility to assess possible cognitive impairment in Judge Newman. I will outline my reasoning for this in the sections below.

<sup>3</sup> Aaron Filler, *Consultation Report*, (unpublished report, 2024) (on file with author).

<sup>4</sup> Filler, *Consultation Report*, at 4.

<sup>5</sup> Filler, *Consultation Report*, at 4.

<sup>6</sup> Filler, *Consultation Report*, at 8.

<sup>7</sup> Filler, *Consultation Report*, at 40.



**SECTION 1.1: Dr. Filler did not perform a comprehensive evaluation consistent with standard practice in assessing cognitive impairment.**

There are standard and accepted methods to assess for cognitive impairment, and simply administering a Perfusion CT scan is not one of them. Dr. Filler stated that his neurological evaluation of Judge Newman was “entirely normal,”<sup>8</sup> but, other than a CT scan, his examination of cognitive problems mainly relied on her self-report of memory problems. The problematic nature of this can be easily seen when considering that Dr. Filler stated that Judge Newman denied repeating herself (“[Immediate Memory] – Not repeating herself”),<sup>9</sup> while there were numerous indications from materials that he reviewed explicitly indicating a tendency to repeat herself (see numerous examples in *Section 2.1*). Despite this contradiction, Dr. Filler opined that Judge Newman “demonstrated appropriate personal insight.”<sup>10</sup> Further, Dr. Filler stated that Judge Newman was “oriented...to person, place, time, and situation,”<sup>11</sup> but simply being oriented to herself, the date, the location, and the situation is not nearly the level of scrutiny expected for an evaluation of possible cognitive impairment for a person in a position with the significant responsibilities of a federal judge.

Dr. Filler’s handwritten notes indicate that Judge Newman denied having changes in face recognition, recalling words to songs, and recalling landmarks; however, this was again based on her self-report only, and these types of impairments would not be likely to be prominent in the early course of a neurodegenerative disease process.<sup>12</sup> Normal functioning in these areas does not preclude possible cognitive impairment. Overlearned information (e.g., knowing landmarks) and behaviors (e.g., engaging in a debate) are much less susceptible to the effects of cognitive decline than is the processing of novel information,<sup>13,14</sup> and this series of questioning was not an effective way to explore possible cognitive deficits.

Dr. Filler’s use of “direct relevant personal experience comparisons relative to two oral arguments in 2019 and 2022 before panels which included Judge Newman”<sup>15</sup> is neither a scientific nor objective process for determining the presence and extent of such impairment. His opinion that “It is highly unlikely that any person suffering from even mild cognitive decline could rapidly understand and explain back this level of

<sup>8</sup> Filler, *Consultation Report*, at 40.

<sup>9</sup> Filler, Handwritten Notes dated 08/24/24, at 1

<sup>10</sup> Filler, *Consultation Report*, at 27.

<sup>11</sup> Filler, *Consultation Report*, at 28.

<sup>12</sup> “Except in severe forms of major neurocognitive disorder, semantic, autobiographical, and implicit learning are relatively preserved, compared with recent memory.”

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>13</sup> Salthouse, T. A. (2019). Trajectories of normal cognitive aging. *Psychology and Aging*, 34(1), 17-24.

<https://doi.org/10.1037/pag0000288>

<sup>14</sup> Hachinski, V., Iadecola, C., Petersen, R. C., Breteler, M. M., Nyenhuis, D. L., Black, S. E., ... & Leblanc, G. G. (2006). National Institute of Neurological Disorders and Stroke–Canadian stroke network vascular cognitive impairment harmonization standards. *Stroke*, 37(9), 2220-2241.

<sup>15</sup> Filler, *Consultation Report*, at 9.



complex technology in disparate fields and then immediately progress to an on target analysis of equally complex patent law issues”<sup>16</sup> is not a scientifically validated way to measure cognitive abilities, as further discussed in *Section 1.6* below, and does not preclude the presence of cognitive impairment.

It is well known that individuals with higher levels of education are more likely to be able to mask clinical manifestations of cognitive impairment, potentially leading to faster objective cognitive decline once symptoms appear.<sup>17,18</sup> Thus, Judge Newman is more likely to be able to “mask” cognitive symptoms outside of standardized cognitive testing, especially when engaging in familiar tasks. Dr. Filler did not even include a screening measure for cognitive impairment (which have their own problems as described in *Section 2*), and he did not directly address Judge Newman’s cognitive abilities using any semblance of an objective cognitive test. This is not in line with the guidelines in the field for assessing mild cognitive impairment or dementia,<sup>19,20,21</sup> as further highlighted in *Section 1.5*.

**SECTION 1.2:** Dr. Filler’s opinion that Judge Newman’s Perfusion CT scan “rules out all of the known causes of MCI...and any dementias” is not based on a method that has widespread acceptance within the relevant scientific community.

Perfusion CT is not used to diagnose cognitive impairment. It is a tool that can help differentiate among different types of impairment once other methods (e.g., cognitive testing) are used, but it is not a replacement for cognitive testing. To be clear, the purpose of this report is not to dismiss the science behind Perfusion CT; rather, it is to demonstrate that the use of this technology alone without a neuropsychological evaluation is an insufficient basis to conclude a definitive lack of cognitive impairment in a fitness for duty context.

Dr. Filler contended that Perfusion CT is exceedingly more objective than cognitive testing. He state, “[U]nlike a situation where there may be a ‘defense neuropsychology report’ and a ‘plaintiff neuropsychology report’ that disagree completely on nearly every conclusion, there is no ‘defense CT scan’ and ‘plaintiff CT scan’ because the data is completely objective requiring little if any subjective interpretation.”<sup>22</sup> This distinction is inaccurate, and research has documented the exact opposite (e.g.,

<sup>16</sup> Filler, *Consultation Report*, at 13.

<sup>17</sup> An, R., Gao, Y., Huang, X., Yang, Y., Yang, C., & Wan, Q. (2024). Predictors of progression from subjective cognitive decline to objective cognitive impairment: A systematic review and meta-analysis of longitudinal studies. *International Journal of Nursing Studies*, 149, 104629.

<sup>18</sup> Meng, X., & D’arcy, C. (2012). Education and dementia in the context of the cognitive reserve hypothesis: a systematic review with meta-analyses and qualitative analyses. *PloS One*, 7(6), e38268.

<sup>19</sup> American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>20</sup> Albert, M. S., DeKosky, S. T., Dickson, D., Dubois, B., Feldman, H. H., Fox, N. C., ... & Phelps, C. H. (2013). The diagnosis of mild cognitive impairment due to Alzheimer’s disease: recommendations from the National Institute on Aging-Alzheimer’s Association workgroups on diagnostic guidelines for Alzheimer’s disease. *Focus*, 11(1), 96-106.

<sup>21</sup> Langa, K. M., & Levine, D. A. (2014). The diagnosis and management of mild cognitive impairment: a clinical review. *Journal of the American Medical Association*, 312(23), 2551-2561.

<sup>22</sup> Filler, *Consultation Report*, at 3.



“These neuroimages have remarkable potential for forensic use, but they are too new, too uncertain, and too laden with troubling questions to earn easy admission to the court.”<sup>23</sup> This has been consistent in literature over time.

Baskin, Edersheim, & Price (2007) commented on the limits to objectivity in neuroimaging. They stated,

*“A brain abnormality does not necessarily imply dysfunction. Most current data allows only correlation, not causality, to be inferred.”*

They further explained,

*“PET, SPECT, and fMRI reveal changes in blood flow that are presumed to reflect changes in local brain cell activity. They essentially represent statistical maps of the probability of a change in local blood flow correlated with some task being carried out by the subject.”<sup>24</sup>*

Regarding the applicability of neuroimaging alone to diagnosing dementia, Henderson (2012) stated,

*“Anatomical imaging studies such as conventional magnetic resonance imaging (MRI) or computed tomography (CT) have limited usefulness in early dementia, except to rule out alternative diagnoses, such as hemorrhage, unsuspected lesions, or tumors.”*

While multiple studies have documented volumetric changes in the hippocampus and the medial temporal lobe associated with Alzheimer’s disease, the technology is not yet advanced enough to differentiate between different types of dementia based on the current knowledge of early anatomical changes.<sup>25</sup>

Similarly, de-Wit and colleagues (2016), stated,

*“To many researchers, the idea that neuroimaging might be assumed to provide a direct measure of information is so obviously false that questioning it might seem like nothing but a straw man argument.”<sup>26</sup>*

This has not changed in recent years. In 2019, Gkotsi, Gasser, and Moulin examined twenty-seven cases that presented neuroscientific evidence in trials, and they found that:

*“While neuroimaging evidence is often presented by the defense as a scientific method able to offer a precise diagnosis of the pathology in question, our case analysis shows that the very same neurobiological evidence can be interpreted in different — sometimes diametrically opposed — ways by defense and State experts.”*

They went on to state:

<sup>23</sup> Moriarty, J. C. (2008). Flickering admissibility: neuroimaging evidence in the US courts. *Behavioral Sciences & The Law*, 26(1), 29-49.

<sup>24</sup> Baskin, J. H., Edersheim, J. G., & Price, B. H. (2007). Is a picture worth a thousand words? Neuroimaging in the courtroom. *American Journal of Law & Medicine*, 33(2-3), 239-269.

<sup>25</sup> Henderson, T. A. (2012). The diagnosis and evaluation of dementia and mild cognitive impairment with emphasis on SPECT Perfusion neuroimaging. *CNS Spectrums*, 17(4), 176-206.

<sup>26</sup> de-Wit, L., Alexander, D., Ekroll, V., & Wagemans, J. (2016). Is neuroimaging measuring information in the brain? *Psychonomic Bulletin & Review*, 23, 1415-1428.



*“Conflicting testimony about the same empirical evidence goes against the hypothesis of neuroscientific techniques constituting ‘objective and hard evidence,’ able to reach solid, scientific, and objective conclusions. Frequent conflicts between neuroimaging experts require the courts to deal with the resulting uncertainty.”<sup>27</sup>*

Perfusion CT is not sensitive enough to elucidate the presence of cognitive problems on its own. Images showing blood flow do not definitively rule in or rule out cognitive disorders, nor do they tell you how those brain cells are functioning. For example, if Judge Newman’s Perfusion CT scan showed markedly reduced blood flow, the appropriate conclusion would not be that Judge Newman was unable to fulfil her duties without further evaluation; that is, results from a Perfusion CT scan cannot be the definitive basis for ruling in or ruling out cognitive impairment with regard to fitness for duty.

Neuroimaging results are not a recognized and acceptable way to measure cognitive impairment. As Gaudet and Marchant (2016) stated, the attempted use of neuroimaging evidence is premature, inappropriate, and—at best—allows only for correlation, not causality, to be inferred.<sup>28</sup> This is consistent with other studies. For example, Treadway and Buckholtz (2011) stated,

*“Simply determining that damage is present says little regarding the implications of such damage...Rather, this gap is bridged by the standard forms of neuropsychological assessment that seek to reveal specific cognitive and behavioral impairments that have more direct relevance for a client’s actions, for which neuroimaging data merely serve as context or precondition.”<sup>29</sup>*

Thus, Dr. Filler’s opinion that Perfusion CT “is far more accurate and specific than neuropsychological testing”<sup>30</sup> in diagnosing cognitive impairment and that the results of Judge Newman’s scan “are decisive”<sup>31</sup> in ruling out cognitive impairment are not consistent with scientific principles and accepted methods in the field and do not accurately represent the use of neuropsychological assessment in the evaluation of cognitive impairment.

**SECTION 1.3: A “normal” Perfusion CT scan does not obviate the need for generally accepted and objective neuropsychological testing.**

<sup>27</sup> Gkotsi, G. M., Gasser, J., & Moulin, V. (2019). Neuroimaging in criminal trials and the role of psychiatrists expert witnesses: A case study. *International Journal of Law and Psychiatry*, 65, 101359.

<sup>28</sup> Gaudet, L. M., & Marchant, G. E. (2016). Under the radar: Neuroimaging evidence in the criminal courtroom. *Drake Law Review*, 64, 577.

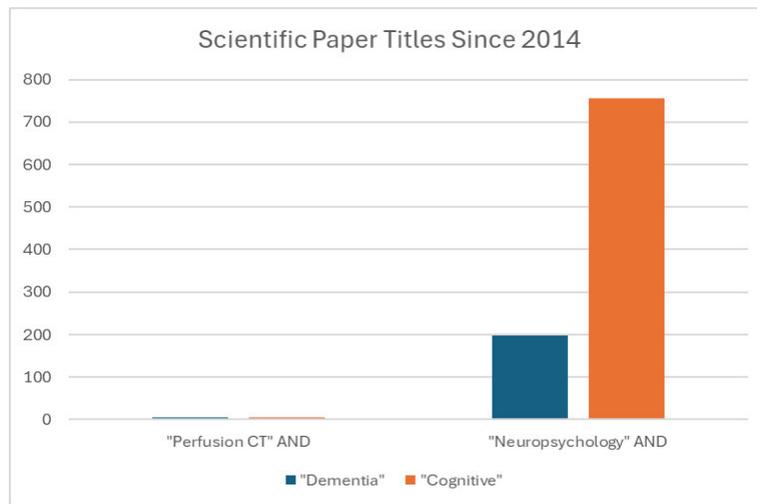
<sup>29</sup> Treadway, M. T., & Buckholtz, J. W. (2011). On the use and misuse of genomic and neuroimaging science in forensic psychiatry: current roles and future directions. *Child and Adolescent Psychiatric Clinics*, 20(3), 533-546.

<sup>30</sup> Filler, *Consultation Report*, at 32.

<sup>31</sup> Filler, *Consultation Report*, at 8.



According to PubMed,<sup>32</sup> only six articles have ever been published with the words “Perfusion CT” and “dementia” in the title,<sup>33</sup> and only five articles have ever been published with the words “Perfusion CT” and “cognitive” in the title.<sup>34</sup> This does not mean that more articles have not been published about Perfusion CT and cognitive impairment (i.e., some may have been written with different wording in the title), but the difference is staggering when the same searches are performed replacing “Perfusion CT” with “neuropsychology”; 606 articles for “dementia”<sup>35</sup> and 1,399 articles for “cognitive.”<sup>36</sup> This does not change when the publication date is restricted to the past 10 years (198 articles for “dementia” and 756 articles for “cognitive” since 2014). Simply put, neuropsychological testing is used exponentially more frequently to assess cognitive impairment in research than is Perfusion CT, and this is also consistent with clinical practice.



Perfusion CT has been used to differentiate between different types of pathology, but it is not used in a clinical setting to diagnose cognitive impairment on its own. Dr. Filler cited a study that examined the possible use of Perfusion CT in this way, but that same study also stated:

*“[The] role of PCT in evaluation of dementias is still at a nascent stage.”<sup>37</sup>*

<sup>32</sup> PubMed is a database created by the National Center for Biotechnology Information (NCBI) at the National Library of Medicine (NLM), a branch of the National Institutes of Health (NIH). It was designed to offer access to citations (abstracts) from biomedical journals. (Canese, K., & Weis, S. (2013). PubMed: the bibliographic database. *The NCBI Handbook*, 2(1).) It has become the most popular and one of the most reliable web resources for clinicians and researchers to find scientific research. (Falagas, M. E., Pitsouni, E. I., Malietzis, G. A., & Pappas, G. (2008). Comparison of PubMed, Scopus, web of science, and Google scholar: strengths and weaknesses. *The FASEB Journal*, 22(2), 338-342.)

<sup>33</sup> Using the search terms “(“Perfusion CT”[Title]) AND (“dementia”[Title])” or “(“CT Perfusion”[Title]) AND (“dementia”[Title])”

<sup>34</sup> Using the search terms “(“Perfusion CT”[Title]) AND (“cognitive”[Title])” or “(“CT Perfusion”[Title]) AND (“cognitive”[Title])”

<sup>35</sup> Using the term “(neuropsycholog\*[Title]) AND (“dementia”[Title])”

<sup>36</sup> Using the term “(neuropsycholog\*[Title]) AND (“cognitive”[Title])”

<sup>37</sup> Dash, S., Agarwal, Y., Jain, S., Sharma, A., & Chaudhry, N. (2023). Perfusion CT imaging as a diagnostic and prognostic tool for dementia: prospective case-control study. *Postgraduate Medical Journal*, 99(1170), 318-325.

Research methods involving neuroimaging technologies like Perfusion CT in the evaluation of cognitive impairment “still lack the level of precision and insight needed for bringing neuroimaging tools into clinical care contexts,”<sup>38</sup> and “further refinement of parameters is needed.”<sup>39</sup> Biomarkers (e.g., blood tests, neuroimaging results) also “do not provide any certainty about a person’s future mental status.”<sup>40</sup> Normal neuroimaging does not preclude impairment, as individuals with normal neuroimaging findings can go on to exhibit significant signs of cognitive impairment<sup>41</sup> due to conditions such as lymphoma,<sup>42</sup> brain cancer,<sup>43</sup> and cerebellar ataxia,<sup>44</sup> among others. Because individuals with normal or inconclusive neuroimaging are sometimes later found to have definitive signs of pathology,<sup>45</sup> these scans are not definitive “pictures” of someone’s actual neurological or cognitive functioning that can be the sole basis to rule out cognitive impairment.

Few studies have directly addressed the effectiveness of using Perfusion CT to diagnose dementia. In studies that have done so, neuropsychological testing was used as the gold standard comparison. For example, in a 2021 study cited by Dr. Filler in his report, Dash and colleagues found Perfusion CT to be helpful in differentiating vascular dementia from Alzheimer’s disease and that Perfusion parameters showed positive correlation with MoCA (cognitive test) scores; however, the results of this study used DSM-5 diagnosis<sup>46</sup> as the basis for determining the diagnostic groups in the first place.<sup>47</sup> That is, research done to determine if

<sup>38</sup> Etkin, A. (2019). A reckoning and research agenda for neuroimaging in psychiatry. *American Journal of Psychiatry*, 176(7), 507-511.

<sup>39</sup> Thiruganachandran, T., Aitchison, S. G., Lim, A., Ding, C., Ma, H., & Phan, T. (2023). Assessing the diagnostic accuracy of CT Perfusion: a systematic review. *Frontiers in Neurology*, 14, 1255526.

<sup>40</sup> Hoffman, S. (2022). Cognitive decline and the workplace. *Wake Forest Law Review*, 57, 115.

<sup>41</sup> Sutherland, M., Kirk, A., Karunanayake, C. P., O’Connell, M. E., & Morgan, D. G. (2022). What happens to the worried well? Follow-up of subjective cognitive impairment. *Canadian Journal of Neurological Sciences*, 49(1), 84-92.

<sup>42</sup> Richie, M. B., Guterman, E. L., Shah, M. P., & Cha, S. (2022). Susceptibility-weighted imaging of intravascular lymphoma of the central nervous system. *JAMA Neurology*, 79(1), 86-87.

<sup>43</sup> Thaler, P. B., Li, J. Y., Isakov, Y., Black, K. S., Schulder, M., & Demopoulos, A. (2012). Normal or non-diagnostic neuroimaging studies prior to the detection of malignant primary brain tumors. *Journal of Clinical Neuroscience*, 19(3), 411-414.

<sup>44</sup> Esmail, S. (2018). Cerebellar ataxia but normal neuroimaging: now what. *Journal of Medical Clinical Research and Reviews*, 2(6), 1-5.

<sup>45</sup> Restrepo-Martinez, M., Ruiz-Garcia, R., Houpt, J., Ang, L. C., Chaudhari, S., & Finger, E. (2024). The diagnostic challenges of late-onset neuropsychiatric symptoms and early-onset dementia: A clinical and neuropathological case study. *Cognitive and Behavioral Neurology*, 10-1097.

<sup>46</sup> As stated in the DSM-5, “Neuropsychological testing, with performance compared with norms appropriate to the patient’s age, educational attainment, and cultural background, is part of the standard evaluation of NCDs and is particularly critical in the evaluation of mild NCD.” The criteria require documentation of “impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment,” and it is not at all indicated that a brain scan would be an appropriate substitution.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

<sup>47</sup> “25 patients presenting with cognitive impairment and diagnosed as dementia as per the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM- V) criteria were included. They were assigned to either VaD or AD subgroup as per DSM-V criteria for each.”

Dash, S., Agarwal, Y., Jain, S., Sharma, A., & Chaudhry, N. (2023). Perfusion CT imaging as a diagnostic and prognostic tool for dementia: prospective case–control study. *Postgraduate Medical Journal*, 99(1170), 318-325.

As shown in Section 1.5 below, the DSM-5-TR criteria specifically recommend neuropsychological testing.



Perfusion CT is a reliable way to diagnose dementia (which is still in its nascency) currently relies on more generally accepted methods that involve neuropsychological testing to determine whether the subjects actually suffered from cognitive impairment.

The diagnostic criteria for major or mild neurocognitive disorder (i.e., “dementia”) in the DSM-5-TR involve neuropsychological testing or another qualified assessment (which would not be brain scan by itself). The DSM-5-TR states, “Neuropsychological testing, with performance compared with norms appropriate to the individual’s age, sex, educational attainment, and cultural background, is part of the standard evaluation of NCDs [neurocognitive disorders] and is particularly critical in the evaluation of mild NCD.”<sup>48</sup> Perfusion CT is not mentioned in the DSM-5-TR criteria, nor is it used as a stand-alone diagnostic criterion in international consensus criteria used by clinicians to diagnose Alzheimer’s disease.<sup>49</sup> The DSM-5-TR states that neuroimaging studies can be helpful “[i]n distinguishing among etiological subtypes,”<sup>50</sup> but it is not used for diagnosis by itself. Researchers using neuroimaging have highlighted the potential usefulness of the technology, especially in distinguishing between different types of dementia, but they are careful to indicate that this technology “should not be used in isolation, rather as an adjunct, and interpreted in the context of clinical information and paraclinical test results.”<sup>51</sup> More pointedly, the main role of neuroimaging in the study of dementia is often isolated to describing the brain, not diagnosing it.<sup>52,53</sup>

While, as Dr. Filler cited, there have been studies showing *potential* biomarkers for frontotemporal dementia,<sup>54</sup> the actual diagnosis of frontotemporal dementia remains a clinical one (i.e., made by a physician rather than the presence of a single biomarker) and typically involves neuropsychological testing as an

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<sup>48</sup> American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>49</sup> e.g., Albert, M. S., DeKosky, S. T., Dickson, D., Dubois, B., Feldman, H. H., Fox, N. C., ... & Phelps, C. H. (2013). The diagnosis of mild cognitive impairment due to Alzheimer’s disease: recommendations from the National Institute on Aging-Alzheimer’s Association workgroups on diagnostic guidelines for Alzheimer’s disease. *Focus*, 11(1), 96-106.

<sup>50</sup> American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>51</sup> Yeo, J. M., Lim, X., Khan, Z., & Pal, S. (2013). Systematic review of the diagnostic utility of SPECT imaging in dementia. *European Archives of Psychiatry and Clinical Neuroscience*, 263, 539-552.

<sup>52</sup> Hachinski, V., Iadecola, C., Petersen, R. C., Breteler, M. M., Nyenhuis, D. L., Black, S. E., ... & Leblanc, G. G. (2006). National Institute of Neurological Disorders and Stroke–Canadian stroke network vascular cognitive impairment harmonization standards. *Stroke*, 37(9), 2220-2241.

<sup>53</sup> Bigler, E. D. (2017). Structural neuroimaging in neuropsychology: History and contemporary applications. *Neuropsychology*, 31(8), 934.

<sup>54</sup> Pasternak, M., Mirza, S. S., Luciw, N., Mutsaerts, H. J., Petr, J., Thomas, D., ... & Deramecourt, V. (2024). Longitudinal cerebral Perfusion in presymptomatic genetic frontotemporal dementia: GENFI results. *Alzheimer’s & Dementia*, 20(5), 3525-3542.



essential part of the diagnosis.<sup>55,56,57,58</sup> Thus, simply undergoing a brain scan is not a replacement for standardized, reliable, and widely accepted methods (i.e., neuropsychological testing) to assess cognitive functioning.<sup>59</sup>

**SECTION 1.4:** Dr. Filler mischaracterized the objective nature and accepted practice of neuropsychological testing for the assessment of cognitive impairment.

Dr. Filler offered numerous statements about neuropsychology without citation. These included statements that neuropsychology is “not tethered to neuroanatomy or neurophysiology,”<sup>60</sup> is “subjective and rooted in a testing framework arising in the 16th century,”<sup>61</sup> and “is non-medical, not administered by physicians, and...ultimately cannot serve as an objective basis for assessment.”<sup>62</sup> These statements are not accurate. As described above, neuropsychological testing is recognized as an essential component in diagnostic criteria for cognitive impairment<sup>63,64,65</sup> and continues to be a widely recognized scientific process to measure cognitive abilities.

Neuropsychological assessment involves the administration of a group of cognitive tests that directly measure abilities such as memory, attention, language, executive functioning, spatial abilities, and motor abilities. The tests are standardized, and results are determined by comparing to known populations and/or those of the same age, sex, and/or educational attainment. Standardized and reliable cognitive tests are needed, as intuition and clinical judgment alone are also not a sufficient replacement for neuropsychological testing.<sup>66</sup>

<sup>55</sup> Kamath, V., Chaney, G. A. S., DeRight, J., & Onyike, C. U. (2019). A meta-analysis of neuropsychological, social cognitive, and olfactory functioning in the behavioral and language variants of frontotemporal dementia. *Psychological Medicine*, 49(16), 2669-2680.

<sup>56</sup> Mendez, M. F., Shapira, J. S., McMurtray, A., Licht, E., & Miller, B. L. (2007). Accuracy of the clinical evaluation for frontotemporal dementia. *Archives of Neurology*, 64(6), 830-835.

<sup>57</sup> Gorno-Tempini, M. L., Hillis, A. E., Weintraub, S., Kertesz, A., Mendez, M., Cappa, S. F., ... & Grossman, M. (2011). Classification of primary progressive aphasia and its variants. *Neurology*, 76(11), 1006-1014.

<sup>58</sup> Rascovsky, K., Hodges, J. R., Knopman, D., Mendez, M. F., Kramer, J. H., Neuhaus, J., ... & Miller, B. L. (2011). Sensitivity of revised diagnostic criteria for the behavioural variant of frontotemporal dementia. *Brain*, 134(9), 2456-2477.

<sup>59</sup> Lopez, O. L. (2013). Mild cognitive impairment. *Continuum: Lifelong Learning in Neurology*, 19(2), 411-424.

<sup>60</sup> Filler, *Consultation Report*, at 8.

<sup>61</sup> Filler, *Consultation Report*, at 26.

<sup>62</sup> Filler, *Consultation Report*, at 32.

<sup>63</sup> American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>64</sup> Albert, M. S., DeKosky, S. T., Dickson, D., Dubois, B., Feldman, H. H., Fox, N. C., ... & Phelps, C. H. (2013). The diagnosis of mild cognitive impairment due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Focus*, 11(1), 96-106.

<sup>65</sup> Langa, K. M., & Levine, D. A. (2014). The diagnosis and management of mild cognitive impairment: a clinical review. *JAMA*, 312(23), 2551-2561.

<sup>66</sup> Bouwmans, A. E., & Weber, W. E. (2012). Neurologists' diagnostic accuracy of depression and cognitive problems in patients with parkinsonism. *BMC Neurology*, 12, 1-6.

Neuropsychological assessment is a cornerstone of measuring cognitive abilities and is the expected avenue for exploring potential cognitive deficits as they relate to a potential workplace problem. Neuropsychological assessment involves comprehensive, objective, research-based methods for measuring the presence and extent of cognitive functioning. Neuropsychologists are trained to gather relevant information in a standardized manner and assess brain functioning by psychometric measurements that are compared to known populations. Results are used in diagnosis and treatment plans, and the particular training of neuropsychologists allows them to determine non-neurological sources of cognitive problems (e.g., stress, depression, anxiety, other medical conditions) as well.<sup>67,68,69</sup>

Neuropsychological testing is the industry standard for the objective assessment of cognitive functioning in research and clinical arenas, and it is a central component of the diagnostic criteria (see *Section 1.5*) for many neurological conditions. In addition to diagnosis of cognitive impairment in general, neuropsychological testing has known benefits in distinguishing between normal aging, mild cognitive impairment, and early dementia.<sup>70</sup>

As Reul and colleagues (2016) stated,

*“Standardized neuropsychological assessment is essential to assess the degree and profile of cognitive dysfunctions for clinical diagnosis.”<sup>71</sup>*

According to Galvin and Sadowsky (2012),

*“Neuropsychological testing, with performance compared with norms appropriate to the individual’s age, sex, educational attainment, and cultural background, is part of the standard evaluation of [neurocognitive disorders] and is particularly critical in the evaluation of mild [neurocognitive disorder].”<sup>72</sup>*

This is reflected in standard medical practice. Once cognitive impairment is affirmed by a thorough history and cognitive test data, a clinician may consider further testing such as an MRI, FDG-PET scan, or CSF

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<sup>67</sup> Begali, V. L. (2020). Neuropsychology and the dementia spectrum: Differential diagnosis, clinical management, and forensic utility. *NeuroRehabilitation*, 46(2), 181-194.

<sup>68</sup> Koay, J. M., Spat-Lemus, J., Cornwell, M. A., Sacks-Zimmerman, A., Mandelbaum, S., Kohn, A., ... & Bender, H. A. (2023). The evolving need for neuropsychology in neurosurgical settings: Challenges facing transformative care. *World Neurosurgery*, 170, 277-285.

<sup>69</sup> Donders, J. (2020). The incremental value of neuropsychological assessment: A critical review. *The Clinical Neuropsychologist*, 34(1), 56-87.

<sup>70</sup> Jacova, C., Kertesz, A., Blair, M., Fisk, J. D., & Feldman, H. H. (2007). Neuropsychological testing and assessment for dementia. *Alzheimer's & Dementia*, 3(4), 299-317.

<sup>71</sup> Reul, S., Johnen, A., Duning, T., & Lohmann, H. (2016). EP 122. The effectiveness of standard neuropsychological testing to differentiate behavioral variant of frontotemporal dementia (bvFTD) from Alzheimer’s Dementia (AD)—A retrospective clinical approach. *Clinical Neurophysiology*, 127(9), e292.

<sup>72</sup> Galvin, J. E., & Sadowsky, C. H. (2012). Practical guidelines for the recognition and diagnosis of dementia. *The Journal of the American Board of Family Medicine*, 25(3), 367-382



analysis to determine a cause for impairment as it relates to treatment,<sup>73,74,75</sup> but these methods are not used as the sole basis for diagnosis and decision-making and are not a replacement for objective cognitive testing.

Neuropsychological tests are used to assess for impairment in other positions of high responsibility such as physicians and pilots.<sup>76,77</sup> The FAA has a specialized program involving neuropsychological assessment for pilots with suspected cognitive impairment, and these tests typically use their own “pilot norms” rather than solely assessing performance by age and education.<sup>78</sup> In pilots, neuropsychological test scores have shown strong validity in effectively addressing understanding, recall, and problem solving that was not better explained by experience alone.<sup>79</sup> Similar to aging attorneys,<sup>80</sup> aging physicians are often hesitant to disclose medical concerns or self-monitor their symptoms,<sup>81</sup> and due to their high intelligence they necessitate more comprehensive methods than a simple cognitive screening measure.<sup>82,83</sup> Thus, when considering possible cognitive impairment in a highly educated person in a position of high responsibility, a comprehensive neuropsychological evaluation is warranted.

Neuropsychological evaluation is also specifically required by the Office of Personnel Management (OPM) when mental fitness is at issue. OPM regulations for documentation of a “medical condition that affects safe and efficient performance” requires that a “diagnosis or clinical impression must be justified according to established diagnostic criteria and the conclusions and recommendations must be consistent with generally accepted professional standards.”<sup>84</sup> This information may include medical history, medical tests, “and, in the case of psychiatric examination or psychological assessment, the findings of a mental status examination and/or the results of psychological tests, if appropriate.” Regarding the applicability of neuropsychological testing, 5 CFR 339.301(e)(2) recognizes the need for a licensed psychologist or clinical neuropsychologist when there is an inquiry into a person’s mental fitness. Thus, Dr. Filler’s assertions that neuropsychology is

<sup>73</sup> Petersen, R. C. (2016). Mild cognitive impairment. *CONTINUUM: Lifelong Learning in Neurology*, 22(2), 404-418.

<sup>74</sup> Daffner, K. R., Gale, S. A., Barrett, A. M., Boeve, B. F., Chatterjee, A., Coslett, H. B., ... & Kaufer, D. I. (2015). Improving clinical cognitive testing: report of the AAN Behavioral Neurology Section Workgroup. *Neurology*, 85(10), 910-918.

<sup>75</sup> Budson, A. E., & Solomon, P. R. (2012). New diagnostic criteria for Alzheimer's disease and mild cognitive impairment for the practical neurologist. *Practical Neurology*, 12(2), 88-96.

<sup>76</sup> Vuorio, A., Suhonen-Malm, A. S., Budowle, B., & Bor, R. (2024). European and US Aeromedical Authority Guidance for Neurocognitive Evaluation of Airline Pilots With Mental Disorders. *Aviation Psychology and Applied Human Factors*.

<sup>77</sup> Federal Aviation Administration. (2024, June 26). Neurocognitive conditions. Retrieved January 06, 2025, from [https://www.faa.gov/ame\\_guide/dec\\_cons/disease\\_prot/neurocog](https://www.faa.gov/ame_guide/dec_cons/disease_prot/neurocog)

<sup>78</sup> Federal Aviation Administration. (2024, June 26). *Specifications for neuropsychological evaluations for potential neurocognitive impairment*. [https://www.faa.gov/ame\\_guide/media/NPevalspecs\\_neurocog\\_impairment.pdf](https://www.faa.gov/ame_guide/media/NPevalspecs_neurocog_impairment.pdf)

<sup>79</sup> Graver, C. J., Armistead-Jehle, P., & Fritch, A. M. (2021). Neuropsychologist’s guide to aeromedical examinations in the military. *Military Behavioral Health*, 9(1), 89-100.

<sup>80</sup> Badger, M. J., Jalonen, E., Long, M., & Harrell, T. L. (2015). Concerns about cognitive impairment and older lawyers. *Experience*, 25, 30.

<sup>81</sup> District of Columbia Bar. (2019, October). *Ethics Opinion 377*. Retrieved January 06, 2025, from <https://dcbbar.org/for-lawyers/legal-ethics/ethics-opinions-210-present/ethics-opinion-377>

<sup>82</sup> Williams, B. W., Flanders, P., Grace, E. S., Korinek, E., Welindt, D., & Williams, M. V. (2017). Assessment of fitness for duty of underperforming physicians: The importance of using appropriate norms. *PLoS One*, 12(10), e0186902.

<sup>83</sup> Rentz, D. M., Huh, T. J., Faust, R. R., Budson, A. E., Scinto, L. F., Sperling, R. A., & Daffner, K. R. (2004). Use of IQ-adjusted norms to predict progressive cognitive decline in highly intelligent older individuals. *Neuropsychology*, 18(1), 38.

<sup>84</sup> Code of Federal Regulations, Title 5, § 339.104 (2023). <https://www.ecfr.gov>



a subjective field based on outdated methods is not in line with clinical practice, research, diagnostic standards in the field, or governmental guidelines.

**SECTION 1.5:** There are official criteria and guidelines used to diagnose cognitive impairment, and they do not involve simply administering a Perfusion CT scan.

The consensus diagnostic criteria for mild cognitive impairment due to Alzheimer’s disease require “objective evidence of impairment in one or more cognitive domains,”<sup>85</sup> and this refers to neuropsychological testing. Similarly, diagnosis of Alzheimer’s disease is typically based on either DSM-5-TR, the National Institute of Neurological, Communicative Disorders and Stroke–Alzheimer Disease and Related Disorders Association (NINCDS-ADRDA) criteria, or the National Institute on Aging–Alzheimer’s Association (NIA-AA) criteria.<sup>86</sup> All of these criteria include neuropsychological testing. The NINCDS-ADRDA criteria support a clinical diagnosis of Alzheimer’s even in the absence of a definitive diagnostic biomarker (e.g., a neuroimaging study),<sup>87</sup> meaning that the diagnosis can be made using neuropsychological test results without a biomarker, but not vice-versa.

The NIA-AA core criteria state that “[Alzheimer’s disease] dementia is fundamentally a clinical diagnosis. To make a diagnosis of AD dementia with biomarker support, the core clinical diagnosis of AD dementia must first be satisfied.” The core clinical criteria include problems functioning at work or other usual activities and cognitive impairment detected and diagnosed through a combination of “history-taking from the patient and a knowledgeable informant” along with an objective cognitive assessment. The objective cognitive assessment is expected to be neuropsychological testing whenever possible. The NIA-AA criteria leave room for a “bedside instrument” (e.g., MMSE, MoCA) to be used, but the criteria also state that “Neuropsychological testing should be performed when the routine history and bedside mental status examination cannot provide a confident diagnosis,”<sup>88</sup> and thus the criteria emphasize the preferential use of neuropsychological testing.<sup>89</sup> As described in other areas of this section and in *Section 2*, the evaluations done with Judge Newman have not been sufficient to render a confident diagnosis, and further testing is indicated. Cognitive and behavioral impairment defined by the NIA-AA criteria include problems with memory (e.g., repetitive questions, misplacing personal belongings, forgetting recent events), reasoning

<sup>85</sup> Albert, M. S., DeKosky, S. T., Dickson, D., Dubois, B., Feldman, H. H., Fox, N. C., ... & Phelps, C. H. (2013). The diagnosis of mild cognitive impairment due to Alzheimer’s disease: recommendations from the National Institute on Aging–Alzheimer’s Association workgroups on diagnostic guidelines for Alzheimer’s disease. *Focus*, 11(1), 96-106.

<sup>86</sup> Cerullo, E., Quinn, T. J., McCleery, J., Vounzoulaki, E., Cooper, N. J., & Sutton, A. J. (2021). Interrater agreement in dementia diagnosis: A systematic review and meta-analysis. *International Journal of Geriatric Psychiatry*, 36(8), 1127-1147.

<sup>87</sup> Galvin, J. E., & Sadowsky, C. H. (2012). Practical guidelines for the recognition and diagnosis of dementia. *The Journal of the American Board of Family Medicine*, 25(3), 367-382.

<sup>88</sup> McKhann, G. M., Knopman, D. S., Chertkow, H., Hyman, B. T., Jack Jr, C. R., Kawas, C. H., ... & Phelps, C. H. (2011). The diagnosis of dementia due to Alzheimer’s disease: Recommendations from the National Institute on Aging–Alzheimer’s Association workgroups on diagnostic guidelines for Alzheimer’s disease. *Alzheimer’s & dementia*, 7(3), 263-269.

<sup>89</sup> Weinstein, A., Gujral, S., Butters, M., Bowie, C., Fischer, C., Flint, A., ... & PACT-MD Study Group. (2020). Diagnosing cognitive decline: comparing NIA-AA to DSM-5 approaches. *The American Journal of Geriatric Psychiatry*, 28(4), S79-S80.

(e.g., poor planning of complex or sequential activities), visuospatial abilities (e.g., recognizing objects in direct view, inability to operate simple instruments), language (e.g., difficulty thinking of common words while speaking, writing errors), and personality changes (e.g., uncharacteristic mood fluctuations).<sup>90</sup>

In the DSM-5-TR, conditions related to cognitive decline are covered under the umbrella of “neurocognitive disorders.” As elucidated below, the DSM-5-TR criteria specifically require the use of a quantified clinical assessment—preferably standardized neuropsychological testing—for the diagnosis.

**Table 1.6.1**

**Evidence of Cognitive decline in DSM-5-TR Criteria for Neurocognitive Disorders (FKA “Dementia”)<sup>83</sup>**

Evidence of modest (Mild NCD) or significant (Major NCD) cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild (Mild NCD) or significant (Major NCD) decline in cognitive function; **and**
2. A modest (Mild NCD) or substantial (Major NCD) impairment in cognitive performance, **preferably documented by standardized neuropsychological testing** [emphasis added] or, in its absence, another quantified clinical assessment.

Criteria used to diagnose conditions of cognitive impairment do not ignore the utility of biomarkers, but the use of such markers (e.g., results from a CT scan) are typically reserved for differentiation among different sources of dysfunction rather than determination of cognitive impairment itself. For example, in addition to the use of neuropsychological testing as objective evidence to diagnose mild cognitive impairment, the criteria suggest biomarkers to assist in differentiating among different causes of dementia. However, Perfusion CT was not one of the biomarkers indicated, and none of the biomarkers are used in isolation. These diagnostic guidelines require evidence of a cognitive concern from any party and impairment in one or more cognitive domains greater than expected for age and education, as indicated by objective evidence of cognitive decline in the form of neuropsychological testing.<sup>92</sup>

<sup>90</sup> McKhann, G. M., Knopman, D. S., Chertkow, H., Hyman, B. T., Jack Jr, C. R., Kawas, C. H., ... & Phelps, C. H. (2011). The diagnosis of dementia due to Alzheimer’s disease: Recommendations from the National Institute on Aging-Alzheimer’s Association workgroups on diagnostic guidelines for Alzheimer’s disease. *Alzheimer’s & dementia*, 7(3), 263-269.

<sup>91</sup> Adapted from the DSM-5-TR for brevity.

<sup>92</sup> Langa, K. M., & Levine, D. A. (2014). The diagnosis and management of mild cognitive impairment: a clinical review. *JAMA*, 312(23), 2551-2561.

**SECTION 1.6:** Dr. Filler’s opinion about Judge Newman’s abilities based on a comparison of her activity during his oral arguments in front of her in 2019 and 2022 and his interview of her in 2024 is highly subjective, unscientific, and unreliable.

Dr. Filler’s opinion about Judge Newman’s abilities based on his analysis of her activity during his oral arguments in front of her in 2019 and 2022<sup>93</sup> is subjective and improper. It is not a tested technique, has not been subject to peer review, has no known potential error rate, has no standards to control its operation, and does not have widespread acceptance within the relevant scientific community.

**SECTION 1.7:** Dr. Filler’s opinion that there was “no material concern that requires further medical testing” was not based on a comprehensive evaluation and ignores common and obvious signs of possible impairment provided in the materials he reviewed.

A fitness for duty evaluation and report should meet the standards of a high-quality evaluation informed by a thorough history, collateral information, job performance data, and psychometric and laboratory testing as needed.<sup>94,95</sup> Similarly, the DC Bar has emphasized the importance of exploring possible mental impairment to determine the extent or presence of such impairment and whether it is chronic or temporary in the context of a fitness for duty evaluation.<sup>96</sup>

With regard to possible memory problems, Dr. Filler primarily relied on Judge Newman’s self-report,<sup>97</sup> which is problematic for many reasons. In a fitness for duty evaluation, the employee’s self-report should not be taken at face value, and the evaluator “should consider all sources of information, and identify or obtain additional data from others or from documents.”<sup>98</sup> If these sources provide discrepant data, that should be reconciled with a more thorough evaluation, as opposed to Dr. Filler’s stance (“I do not endeavor to resolve which recollection is more accurate.”)<sup>99</sup> Often, the prominent referral question in a neuropsychological fitness for duty evaluation is determine whether documented cognitive impairment is present when there are two opposing viewpoints.

<sup>93</sup> Filler, *Consultation Report*, at 9.

<sup>94</sup> Anfang, S. A., Faulkner, L. R., Fromson, J. A., & Gendel, M. H. (2005). The American Psychiatric Association’s resource document on guidelines for psychiatric fitness-for-duty evaluations of physicians. *Journal of the American Academy of Psychiatry and the Law Online*, 33(1), 85-88.

<sup>95</sup> Finlayson, A. R., Dietrich, M. S., Neufeld, R., Roback, H., & Martin, P. R. (2013). Restoring professionalism: The physician fitness-for-duty evaluation. *General Hospital Psychiatry*, 35(6), 659-663.

<sup>96</sup> District of Columbia Bar. (2019, October). *Ethics Opinion 377*. Retrieved January 06, 2025, from <https://dcbar.org/for-lawyers/legal-ethics/ethics-opinions-210-present/ethics-opinion-377>

<sup>97</sup> Dr. Filler’s handwritten notes indicate that Judge Newman denied experiencing problems related to immediate memory and long-term memory.

<sup>98</sup> Wettstein, R. M. (2013). Fitness-for-duty evaluations. In L. H. Gold & D. L. Vanderpool (Eds.), *Clinical Guide to Mental Disability Evaluations* (pp. 309–336). Springer Science + Business Media. [https://doi.org/10.1007/978-1-4614-5447-2\\_12](https://doi.org/10.1007/978-1-4614-5447-2_12)

<sup>99</sup> Filler, *Consultation Report*, at 27.

In attorneys, signs of cognitive impairment can include forgetting information during a hearing or important docket dates, failing to recall settled case law, forgetting colleagues' names, missing calls or meetings despite having an up-to-date calendar, failing to use technology in a manner that was previously done, and unexplained changes to mood and demeanor.<sup>100</sup> Several of these same issues were presented in the materials from the Special Committee that Dr. Filler reviewed (see *Section 2*).

Careful history taking is especially important in a fitness for duty evaluation involving potential cognitive problems in the elderly to help distinguish normal aging from early signs of a more serious disease process.<sup>101</sup> Because the individual with suspected cognitive problems may not be the most reliable source, it is important to consider the observations of outside observers. The lack of awareness of illness is indeed a known symptom of Alzheimer's disease and other dementias, and it is referred to as *anosognosia*.<sup>102,103,104,105,106</sup> Thus, in an evaluation for cognitive impairment, it is customary to rely not only on the report of the individual, but also others around them (known as "collateral informants" in the clinical world). Considering the *sui generis* nature of this case, access to informant sources may be limited to the experiences of those who interact with Judge Newman at work.

Dr. Filler did not give proper weight to descriptions of concerning behaviors from Judge Newman's coworkers. Several individuals working around Judge Newman described events that were clearly concerning (see *Section 2.I*), and while they do not lead to a definitive conclusion of cognitive impairment on their own, they should undoubtedly be considered in an evaluation for cognitive impairment. Instead, Dr. Filler dismissed the numerous affidavits written by individuals at Judge Newman's workplace, stating, "I do not endeavor to resolve which recollection is more accurate."<sup>107</sup> The information provided in these affidavits is important collateral information that is routinely used in the diagnosis of possible cognitive impairment. Even if one were to take Dr. Filler's approach regarding the conflicting reports, objective, standardized, and widely accepted neuropsychological testing is best suited to objectively identify cognitive concerns when an

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<sup>100</sup> Sauber, J. (2020). Lawyers with dementia. *Bench & Bar of Minnesota*, 77(9).

<sup>101</sup> Galvin, J. E., & Sadowsky, C. H. (2012). Practical guidelines for the recognition and diagnosis of dementia. *The Journal of the American Board of Family Medicine*, 25(3), 367-382

<sup>102</sup> Cacciamani, F., Houot, M., Gagliardi, G., Dubois, B., Sikkes, S., Sánchez-Benavides, G., ... & Epelbaum, S. (2021). Awareness of cognitive decline in patients with Alzheimer's disease: a systematic review and meta-analysis. *Frontiers in Aging Neuroscience*, 13, 697234.

<sup>103</sup> Prigatano, G. P., Russell, S., & Meites, T. M. (2024). Studying lack of awareness of cognitive decline in neurodegenerative diseases requires measures of both anosognosia and denial. *Frontiers in Aging Neuroscience*, 15, 1325231.

<sup>104</sup> Johansson, M. M., Marcusson, J., & Wressle, E. (2015). Cognitive impairment and its consequences in everyday life: experiences of people with mild cognitive impairment or mild dementia and their relatives. *International psychogeriatrics*, 27(6), 949-958.

<sup>105</sup> Cacciamani, F., Sambati, L., Houot, M., Habert, M. O., Dubois, B., & Epelbaum, S. (2020). Awareness of cognitive decline trajectories in asymptomatic individuals at risk for AD. *Alzheimer's Research & Therapy*, 12, 1-10.

<sup>106</sup> Hoffman, S. (2022). Cognitive decline and the workplace. *Wake Forest Law Review*, 57, 115.

<sup>107</sup> Filler, *Consultation Report*, at 27.







in over 25 to 41% of those over 85 years of age.<sup>128,129,130,131</sup> According to the Alzheimer's Association, 33.4% of people over the age of 85 have Alzheimer's dementia,<sup>132</sup> and this figure does not account for other types of dementia or cognitive impairment. This is not meant to imply that everyone over the age of 85 has cognitive impairment, but individuals in this age range, in combination with other factors such as concerns from collateral informants, are substantially more at risk for cognitive decline and indicate the need for further evaluation when present.

Further, the outcome of a neuropsychological fitness for duty evaluation is not necessarily a diagnosis; it is a determination about whether a condition is present that is likely to interfere with the completion of an individual's usual job tasks. This means that an employee can be unfit for duty even without a severe diagnosis such as dementia. Psychological fitness for duty evaluations are often ordered when there is a possible cognitive, psychiatric, or behavioral condition that is affecting one's ability to carry out their usual job tasks. The goal of the evaluation is to determine whether there is a condition present that would impair such tasks and whether certain limitations or restrictions are present.<sup>133</sup> Thus, Dr. Filler's determination that no signs of dementia are present in Judge Newman—even if his methods were valid—would still not preclude the possibility of cognitive impairment, and Perfusion CT is not the standard, accepted, and validated way to determine if cognitive deficits are present.

When considering the possibility of cognitive impairment related to a person's ability to work (i.e., neuropsychological fitness for duty), assessment of possible impairment is more important than a diagnosis, as an individual will begin to exhibit concerning symptoms of cognitive decline prior to meeting full criteria for the condition.<sup>134</sup> In a fitness for duty evaluation for a physician experiencing possible cognitive problems, it is recommended that the mental status examination be expanded, and the individuals should be referred for "psychological, neuropsychological, medical, laboratory, or other examinations or tests."<sup>135</sup> In a neuropsychological fitness for duty examination, the employer's questions about risk in a position of high responsibility center on the potential impact of the employee's neuropathology in the workplace. These

<sup>128</sup> Woodford, H. J., & George, J. (2007). Cognitive assessment in the elderly: a review of clinical methods. *QJM: An International Journal of Medicine*, 100(8), 469-484.

<sup>129</sup> Fei, M., Qu, Y. C., Wang, T., Yin, J., Bai, J. X., & Ding, Q. H. (2009). Prevalence and distribution of cognitive impairment no dementia (CIND) among the aged population and the analysis of socio-demographic characteristics: the community-based cross-sectional study. *Alzheimer Disease & Associated Disorders*, 23(2), 130-138.

<sup>130</sup> Yaffe, K., Middleton, L. E., Lui, L. Y., Spira, A. P., Stone, K., Racine, C., ... & Kramer, J. H. (2011). Mild cognitive impairment, dementia, and their subtypes in oldest old women. *Archives of Neurology*, 68(5), 631-636.

<sup>131</sup> Peltz, C. B., Corrada, M. M., Berlau, D. J., & Kawas, C. H. (2012). Cognitive impairment in nondemented oldest-old: prevalence and relationship to cardiovascular risk factors. *Alzheimer's & Dementia*, 8(2), 87-94.

<sup>132</sup> Alzheimer's Association (2024). 2024 Alzheimer's disease facts and figures. *Alzheimer's & Dementia*, 20, 3708-3821. <https://doi.org/10.1002/alz.13809>

<sup>133</sup> Miller, L. (2007). The psychological fitness-for-duty evaluation. *FBI Law Enforcement Bulletin*, 76, 10.

<sup>134</sup> Galvin, J. E., & Sadowsky, C. H. (2012). Practical guidelines for the recognition and diagnosis of dementia. *The Journal of the American Board of Family Medicine*, 25(3), 367-382

<sup>135</sup> Anfang, S. A., Faulkner, L. R., Fromson, J. A., & Gendel, M. H. (2005). The American Psychiatric Association's resource document on guidelines for psychiatric fitness-for-duty evaluations of physicians. *Journal of the American Academy of Psychiatry and the Law Online*, 33(1), 85-88.



issues typically concern the cognitive abilities of the employee and whether these can be ameliorated so that the particular job can be performed without limitations (i.e., things an individual cannot do due to their condition) or restrictions (i.e., things an individual should not do to avoid harm or worsening their condition).<sup>136</sup>

### Conclusions from Section 1:

As described above, Dr. Filler overstated the reliability, validity, and general acceptance of using Perfusion CT to rule out cognitive impairment. He made incorrect statements about neuropsychology being completely subjective and Perfusion CT being completely objective, and he neglected to take into account that neuropsychological test scores are engrained in the very definitions of various cognitive disorders according to their diagnostic criteria. Dr. Filler relied on Judge Newman's self-report and did not properly weigh the concerns of those around her. Considering such collateral source information is standard procedure in an evaluation for cognitive impairment. Dr. Filler also did not take into account that other conditions aside from dementia could cause potential cognitive impairment. Dr. Filler did not administer a single objective, standardized, or recognized cognitive measure to Judge Newman. His approach of subjectively comparing his impressions of her to his memory of her in an oral argument several years ago is subjective, not recognized, and not standardized. His conclusion that no further evaluation or testing is fundamentally flawed.

## SECTION 2: ANALYSIS OF ADDITIONAL MATERIALS

**SECTION 2.1:** The provided affidavits and declarations highlight concerning signs of possible cognitive decline that warrant further comprehensive investigation with validated methodologies.

Individuals working around Judge Newman for many years have documented concerns about possible decline in her functioning. Acting IT director ██████████ and acting HelpDesk Supervisor ██████████ perceived a significant increase in Judge Newman forgetting how to perform basic tasks that used to be routine for her, and this has reportedly culminated in an increase in help desk calls and frequent assertions that someone was "hacking" her computer despite no evidence of this happening. ██████████ and ██████████ colleagues have perceived Judge Newman to have exhibited a change in personality and demeanor including unjustified concerns about being hacked. ██████████, ██████████, and ██████████ also provided similar accounts. These observations are especially important because neuropsychiatric symptoms such as delusions and paranoia are often identified as the first manifestation of an underlying neurocognitive disorder, and they

<sup>136</sup> Chafetz, M. (2019). Fitness for duty examinations. In L. D. Ravdin & H. L. Katzen (Eds.), *Handbook on the Neuropsychology of Aging and Dementia* (pp. 263-272). Springer. [https://doi.org/10.1007/978-3-319-93497-6\\_17](https://doi.org/10.1007/978-3-319-93497-6_17)

are widely prevalent in individuals with dementia.<sup>137,138</sup> It is common for such symptoms to be persecutory delusions such as delusions of theft,<sup>139,140,141</sup> and more prominent neuropsychiatric symptoms may also make someone more at risk for imminent progression of neurocognitive symptoms.<sup>142,143</sup>

Similarly, ██████████ stated that Judge Newman had become stuck and repetitive about unrelated topics and appeared to be confused, and distrustful of others. The repetitive nature of Judge Newman's discourse was also corroborated by ██████████, who works as the ██████████ ██████████ Human Resources for the United States Court of Appeals for the Federal Circuit. ██████████ included email exchanges in which Judge Newman was repetitive with questions despite being told answers. ██████████, who worked as Judge Newman's paralegal from December 2021 to April 2023, described progressively worsening instances in which Judge Newman had trouble recalling recent events and information, keeping track of case materials, and exhibiting personality changes.

Other materials indicate that Judge Newman later exhibited an apparent lapse in memory related to the departures of two employees of her chambers. On April 19, 2023, Chief Judge Moore authored an email stating that ██████████ was no longer an employee of the Newman chambers. Chief Judge Moore sent another email about the resignation of ██████████ from the Newman chambers about 45 minutes later. Judge Newman replied about an hour after that stating, "I agree that this is appropriate. Please process [sic] John's [sic] departure expeditiously." Eight days later, Judge Newman wrote the following email:

*Judge Moore,*

*I never released my paralegal ██████████ from my chambers staff. His movement to your staff, without consultation with me, violates his confidentiality and other obligations to me. Nor have I released my law clerk ██████████. I observe that he is now listed as "law clerk—chambers of ██████████." This was not cleared with me, and I was never notified of this move, again in violation of the confidentiality of my chambers, and in violation of my right to law clerk services.*

*Judge Newman*

<sup>137</sup> Cipriani, G., Danti, S., Vedovello, M., Nuti, A., & Lucetti, C. (2014). Understanding delusion in dementia: a review. *Geriatrics & Gerontology International*, 14(1), 32-39.

<sup>138</sup> Na, H. R., Kang, D. W., Woo, Y. S., Bahk, W. M., Lee, C. U., & Lim, H. K. (2018). Relationship between delusion of theft and cognitive functions in patients with mild Alzheimer's disease. *Psychiatry Investigation*, 15(4), 413.

<sup>139</sup> Gallagher, D., Fischer, C. E., & Iaboni, A. (2017). Neuropsychiatric symptoms in mild cognitive impairment: an update on prevalence, mechanisms, and clinical significance. *The Canadian Journal of Psychiatry*, 62(3), 161-169.

<sup>140</sup> Martin, E., & Velayudhan, L. (2020). Neuropsychiatric symptoms in mild cognitive impairment: a literature review. *Dementia and Geriatric Cognitive Disorders*, 49(2), 146-155.

<sup>141</sup> Seeman, M. V. (2018). Understanding the delusion of theft. *Psychiatric Quarterly*, 89(4), 881-889.

<sup>142</sup> Sugarman, M. A., Alosco, M. L., Tripodis, Y., Steinberg, E. G., & Stern, R. A. (2018). Neuropsychiatric symptoms and the diagnostic stability of mild cognitive impairment. *Journal of Alzheimer's disease*, 62(4), 1841-1855.

<sup>143</sup> Forrester, S. N., Gallo, J. J., Smith, G. S., & Leoutsakos, J. M. S. (2016). Patterns of neuropsychiatric symptoms in mild cognitive impairment and risk of dementia. *The American Journal of Geriatric Psychiatry*, 24(2), 117-125.



The concerns of others who work around Judge Newman indicated possible serious symptoms of cognitive decline. These concerns are not diagnostic in and of themselves, but are directly in line with the diagnostic definition of a neurocognitive disorder (e.g., Criterion A1 of the DSM-5-TR diagnosis of major neurocognitive disorder, which states, “Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function.”).<sup>144</sup>

**SECTION 2.2:** Dr. Rothstein’s report does not effectively rule out the presence of possible cognitive decline.

Neurologist Ted Rothstein, MD examined Judge Newman on June 21, 2023.<sup>145</sup> He described her medical history as relevant for a pacemaker, hypertension, hyperlipidemia, and hypothyroidism. As described above, these conditions can be related to cognitive impairment in their own right.

Dr. Rothstein administered a brief cognitive screening measure (Montreal Cognitive Assessment; MoCA) to Judge Newman. The MoCA consists of 30 possible points and includes limited questions about information such as the date, recall of a short list of words after a few minutes, naming of animals, drawing of a clock and a complex shape, alternating between a letter and a number, repeating information heard aloud, performing simple mental calculations, and naming words beginning with a certain letter. The MoCA is widely used in an initial assessment of possible cognitive functioning, especially by neurologists and neuropsychiatrists,<sup>146</sup> but it is not comprehensive enough to be used as the sole basis for a fitness for duty evaluation when potential cognitive problems are at issue.

Cognitive screening measures are not substitutes for comprehensive neuropsychological testing. There are times when a brief instrument such as the MoCA may be used to assess for possible cognitive decline, but, as described in the diagnostic criteria for mild cognitive impairment, “the clinician must be mindful that these screening instruments are insufficient to make the diagnosis.”<sup>147</sup> Neuropsychological test results, in contrast, can help the clinician assess whether the level of function is appropriate for the patient’s age, sex, and education. The consensus criteria for the determination of vascular cognitive impairment highlight the importance of formal cognitive testing. They state that formal cognitive testing is preferred because brief

<sup>144</sup> American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>145</sup> Ted Rothstein, *Declaration of Ted L. Rothstein, MD*, (unpublished report, 2024) (on file with author).

<sup>146</sup> Siqueira, G. S., Hagemann, P. D. M., Coelho, D. D. S., Santos, F. H. D., & Bertolucci, P. H. (2019). Can MoCA and MMSE be interchangeable cognitive screening tools? A systematic review. *The Gerontologist*, 59(6), e743-e763.

<sup>147</sup> Petersen, R. C. (2016). Mild cognitive impairment. *CONTINUUM: Lifelong Learning in Neurology*, 22(2), 404-418.

screening measures “will likely be insensitive to subtle cognitive dysfunction during the early stages of [mild cognitive impairment] and will often yield normal performance.”<sup>148</sup>

The lay audience is often under a false assumption that passing a global cognitive screening tool such as the Montreal Cognitive Assessment (MoCA) or the Mini Mental State Examination (MMSE) is akin to a clean bill of cognitive health, but these screening tools are not “dementia tests.” Global cognitive screening tools often have limited sensitivity and specificity outside of their demographic normative samples. People with dementia often pass these screens, and people without dementia often fail them.<sup>149,150</sup> The current gold standards for dementia diagnosis involve a holistic assessment that considers numerous converging sources of evidence, including metabolic assays, physical examination to rule out reversible causes, structural neuroimaging and a broad spectrum neuropsychological assessment that covers memory, language, visuospatial functioning, attention, praxis, and others.<sup>151</sup> With regard to cognitive functioning, this is best captured from trained neuropsychologists administering comprehensive, standardized neuropsychological testing with the data obtained being compared to normal population values.<sup>152</sup>

As stated by Daffner and colleagues (2015),

*“Cognitive testing is essential for evaluating memory and other cognitive complaints associated with neurologic disorders. General cognitive tests, such as the Montreal Cognitive Assessment (MoCA), Addenbrooke’s Cognitive Examination–Revised, or Mini-Mental State Examination (MMSE), are useful for screening but have limited diagnostic specificity.”*<sup>153</sup>

Similarly, Tannou and colleagues (2021) stated,

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<sup>148</sup> Hachinski, V., Iadecola, C., Petersen, R. C., Breteler, M. M., Nyenhuis, D. L., Black, S. E., ... & Leblanc, G. G. (2006). National Institute of Neurological Disorders and Stroke–Canadian stroke network vascular cognitive impairment harmonization standards. *Stroke*, 37(9), 2220-2241.

<sup>149</sup> Reilly, J. (2024). Neuropsychology and Politics Collide in the 2024 US Presidential Election: Pitfalls of attacks on age, language, and memory. *Journal of Neuropsychology*.

<sup>150</sup> Spring, C. C., Hobson, V., Lucas, J. A., Menon, C. V., Hall, J. R., & O’Bryant, S. E. (2012). Diagnostic accuracy of the MMSE in detecting probable and possible Alzheimer’s disease in ethnically diverse highly educated individuals: an analysis of the NACC database. *Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences*, 67(8), 890-896.

<sup>151</sup> Reilly, J. (2024). Neuropsychology and Politics Collide in the 2024 US Presidential Election: Pitfalls of attacks on age, language, and memory. *Journal of Neuropsychology*.

<sup>152</sup> Woodford, H. J., & George, J. (2007). Cognitive assessment in the elderly: a review of clinical methods. *QJM: An International Journal of Medicine*, 100(8), 469-484.

<sup>153</sup> Daffner, K. R., Gale, S. A., Barrett, A. M., Boeve, B. F., Chatterjee, A., Coslett, H. B., ... & Kaufer, D. I. (2015). Improving clinical cognitive testing: report of the AAN Behavioral Neurology Section Workgroup. *Neurology*, 85(10), 910-918.

*“Such simple assessments of cognitive functions are not sufficient to assess a phenomenon as complex as decision-making and need to be completed by complementary neuropsychological assessment exploring the different skills involved in decision-making ability.”<sup>154</sup>*

Cognitive screens, such as the MoCA, are “generally brief and narrow in scope” and more appropriate for a visit with a primary care physician whereas a neuropsychological assessment is “multidimensional in nature and used for purposes such as identifying primary and secondary diagnoses, determining the nature and severity of a person’s cognitive difficulties, determining functional limitations, and planning treatment and rehabilitation.”<sup>155</sup> For example, cognitive screening may be used to inform treatment planning but often lacks consideration of contextual factors and does not offer prognostication regarding functional abilities.<sup>156</sup> Hoffman (2022) asserted that “A large number of tools are available to assess cognitive capacities” and that “Thorough neuropsychological testing takes several hours and is considerably more reliable than brief assessments.”<sup>157</sup> Screening measures are also inappropriate substitutes for more comprehensive cognitive testing in populations with higher intelligence and/or education. For example, false negative results on the MoCA (i.e., concluding no impairment when impairment was actually present) were especially prevalent in cases of high educational and/or professional levels,<sup>158</sup> and MoCA factors such as educational attainment and intelligence should be taken into account when interpreting results of the MoCA.<sup>159</sup>

The MoCA was the only cognitive test that Dr. Rothstein attempted to administer to Judge Newman, and he was only able to partially administer it due to Judge Newman reportedly being unable to write due to a wrist injury. The MoCA administered to Judge Newman was reportedly adapted to not include subtests involving handwriting due to her broken wrist. Dr. Rothstein stated that “Impaired wrist function does not preclude testing of cognitive function,”<sup>160</sup> yet the only measure he administered—a brief one at that—was not administered in a standardized way due to her inability to write. Dr. Rothstein reported that Judge Newman produced a score of 24 out of 28 on a “partial MoCA”<sup>161</sup> because the score did not include drawing of a cube or a following a trail using a pencil due to her hand injury; however, it is unclear how she was able to draw

<sup>154</sup> Tannou, T., Godard-Marceau, A., Joubert, S., Daneault, S., Kergoat, M. J., Magnin, E., ... & Aubry, R. (2021). Added value of functional neuroimaging to assess decision-making capacity of older adults with neurocognitive disorders: protocol for a prospective, monocentric, single-arm study (IMAGISION). *BMJ open*, 11(9), e053549.

<sup>155</sup> Roebuck-Spencer, T. M., Glen, T., Puente, A. E., Denney, R. L., Ruff, R. M., Hostetter, G., & Bianchini, K. J. (2017). Cognitive screening tests versus comprehensive neuropsychological test batteries: a National Academy of Neuropsychology education paper. *Archives of Clinical Neuropsychology*, 32(4), 491-498.

<sup>156</sup> Gaudet, C. E., & Del Bene, V. A. (2022). Neuropsychological assessment of the aging physician: a Review & Commentary. *Journal of Geriatric Psychiatry and Neurology*, 35(3), 271-279.

<sup>157</sup> Hoffman, S. (2022). Cognitive decline and the workplace. *Wake Forest Law Review*, 57, 115.

<sup>158</sup> Dautzenberg, G., Lijmer, J., & Beekman, A. (2019). Diagnostic accuracy of the Montreal Cognitive Assessment (MoCA) for cognitive screening in old age psychiatry: Determining cutoff scores in clinical practice. Avoiding spectrum bias caused by healthy controls.

<sup>159</sup> Bruijnen, C. J., Dijkstra, B. A., Walvoort, S. J., Budy, M. J., Beurmanjer, H., De Jong, C. A., & Kessels, R. P. (2020). Psychometric properties of the Montreal Cognitive Assessment (MoCA) in healthy participants aged 18–70. *International Journal of Psychiatry in Clinical Practice*, 24(3), 293-300.

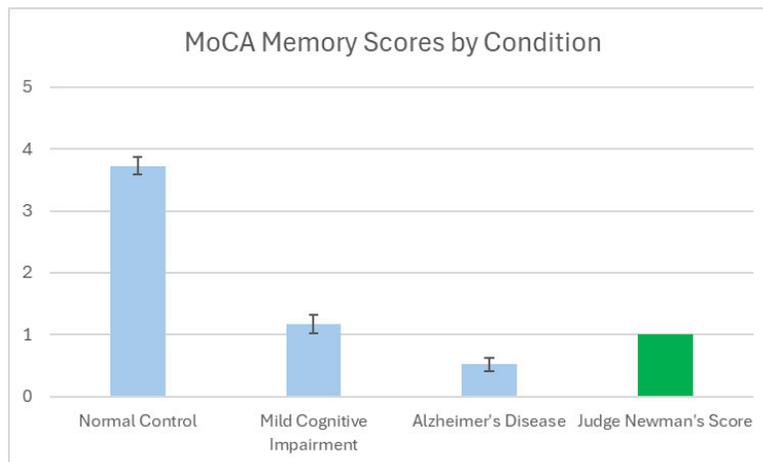
<sup>160</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 1.

<sup>161</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 5.



a clock (and receive a perfect score) if she were unable to use her hand to draw a line connecting numbers and letters or to draw a cube on other parts of the MoCA. The clock drawing would necessarily be included in the remaining 28 points that Dr. Rothstein claimed to assess. It seems probable, however, that she was not able to draw the clock because she could not hold a pen. Thus, her score was likely 21 out of 25.

Based on the items of the MoCA that were administered, Judge Newman exhibited significant problems with memory recall. Judge Newman was unable to recall four out of five words that were read to her minutes earlier, and Dr. Rothstein interpreted this finding as indicating a “slight limitation in immediate memory.”<sup>162</sup> I do not agree with that characterization. Although recalling one out of five memory items on the MoCA is not diagnostic by itself, data from the test publisher indicate that this score is commonly associated with cognitive impairment,<sup>163</sup> which indicates that this memory score may very well be more worrisome than a “slight limitation in immediate memory,”<sup>164</sup> as Dr. Rothstein characterized it to be. As shown in the graph below, Judge Newman’s score of 1 out of 5 is much more in line with groups diagnosed with cognitive impairment.



Dr. Rothstein did not include enough information to calculate the MoCA Memory Index Score (MIS), which not only includes free recall but also varying degrees of recognition cueing (e.g., if a word is not recalled, the test-taker is provided a categorical cue such as that the word was an animal and then a three-item multiple choice cue). Increasingly poor scores on the MIS are strongly associated with development of more severe cognitive disorders. For example, one study found that participants with a MoCA-MIS score less than 7/15

<sup>162</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 5.

<sup>163</sup> <https://mocacognition.com/moca-clinic-data/> derived from Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., ... & Chertkow, H. (2005). The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society*, 53(4), 695-699. Values represent mean scores for each group, and error bars represent Standard Error of the Mean (SEM).

<sup>164</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 5.

at baseline converted to Alzheimer's disease within 18 months on average.<sup>165</sup> Dr. Rothstein did not include Judge Newman's score on the MIS, but her maximum possible score would have been 11/15. The score of 11 out of 15 would only have occurred if Judge Newman provided the correct answer to all four of the words that she did not recall after being provided a category cue (e.g., a type of food). If this did not improve her recall, she should have been given a multiple-choice answer (e.g., was it X, Y, or Z), and the MIS score could then be calculated. Based on the information provided, Judge Newman's MIS score could have ranged from 3/15 (none of the four missing words correct after cueing) to 11/15 (all four missing words correct after category cue).

The results provided by Dr. Rothstein do not fill in any gaps left in Dr. Filler's analysis, and, on the contrary, they introduce documented evidence of memory problems that indicate the need for further testing. Dr. Rothstein ultimately stated that Judge Newman "could have more detailed neuropsychological evaluation as part of her neurological assessment,"<sup>166</sup> along with a brain MRI with NeuroQuant analysis, but he nevertheless concluded that her abilities were "sufficient to continue her participation in her court's proceedings"<sup>167</sup> and that "[His] test demonstrated she had the cognitive function to continue to function as a judge in the court's proceedings."<sup>168</sup> Dr. Rothstein's conclusions did not match his findings. He administered part of a cognitive screening measure, and the part that was administered indicated significant memory concerns (contrary to his assertion that recalling one out of five words presented minutes earlier was a "slight limitation in immediate memory").<sup>169</sup>

**SECTION 2.3:** Dr. Carney's report does not effectively rule out the presence of possible cognitive decline.

Dr. Carney, a general and forensic psychiatrist, was retained by the New Civil Liberties Alliance and an attorney for Judge Newman. Dr. Carney evaluated Judge Newman on August 25, 2023.<sup>170</sup> As with Dr. Filler, Dr. Carney relied on the self-report of Judge Newman, who denied having any significant cognitive problems. Dr. Carney reviewed news articles about the legal dispute and the publicly available filings in the matter, but she did not indicate anywhere in her report or analysis taking into account information from the affidavits. Dr. Carney knew of the existence of the affidavits, as she made reference to Judge Newman contending that they were not accurate. Dr. Carney perceived Judge Newman "to be articulate and respond

<sup>165</sup> Julayanont, P., Brousseau, M., Chertkow, H., Phillips, N., & Nasreddine, Z. S. (2014). Montreal Cognitive Assessment Memory Index Score (MoCA-MIS) as a Predictor of Conversion from Mild Cognitive Impairment to Alzheimer's Disease. *Journal of the American Geriatrics Society*, 62(4), 679-684.

<sup>166</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 5.

<sup>167</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 5.

<sup>168</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 1.

<sup>169</sup> Rothstein, *Declaration of Ted L. Rothstein, MD*, at 5.

<sup>170</sup> Regina Carney, *Independent Medical Examination*, (unpublished report, 2024) (on file with author).

to the concerns raised in a collected manner,”<sup>171</sup> but Judge Newman also reportedly had “no specific recollection of a negative event or experience that might have given rise to the complaint.”<sup>172</sup>

Dr. Carney stated, “Given Judge Newman’s advanced educational attainment and exceptional verbal fluency, the possibility of some degree of successful concealment of an underlying cognitive defect was examined.”<sup>173</sup> This is a valid assumption; however, Dr. Carney chose to address this issue by administering the Modified Mini-Mental Status Exam (3-MS)—a coarse cognitive screening measure that is insensitive to effects of education and intelligence. The limitations of the 3-MS are the same as those described regarding the MoCA above; a screening measure of this type is not appropriate for definitive and comprehensive exploration of cognitive difficulties in a fitness for duty exam.

The abilities measured on the 3-MS include knowing the names of prominent politicians such as the President, Vice President, and Governor, counting backwards from five, pointing to different body parts, spelling a 5-letter word, recalling three words that were presented to her minutes earlier, and being oriented to the date, location, and situation. The 3-MS may be appropriate for a general patient in a neurology office, but it is insufficient to administer this measure in place of a comprehensive neuropsychological evaluation in the present matter. Dr. Carney also administered the Alzheimer Disease Clinical Dementia Rating (CDR), which also does not include formal or objective cognitive testing, and it was her opinion that Judge Newman had no major problems with memory, orientation, judgment, problem solving, social/occupational functioning, and personal care, leading to a Global CDR score of 0.

The 3-MS can be used for screening, but a definitive diagnosis of cognitive impairment requires additional evaluation,<sup>174,175,176</sup> and the CDR is not as effective at determining early signs of cognitive impairment and is better suited for the diagnoses of later stage dementia.<sup>177,178</sup> Further, no screening procedure—including

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<sup>171</sup> Carney, *Independent Medical Examination*, at 3.

<sup>172</sup> Carney, *Independent Medical Examination*, at 3.

<sup>173</sup> Carney, *Independent Medical Examination*, at 5.

<sup>174</sup> Holsinger, T., Plassman, B. L., Stechuchak, K. M., Burke, J. R., Coffman, C. J., & Williams Jr, J. W. (2012). Screening for cognitive impairment: comparing the performance of four instruments in primary care. *Journal of the American Geriatrics Society*, 60(6), 1027-1036.

<sup>175</sup> Li, Y., Tian, X., Xiong, Z. Y., Liao, J. L., Hao, L., Liu, G. L., ... & Dong, J. (2016). Performance of the modified mini-mental state examination (3MS) in assessing specific cognitive function in patients undergoing peritoneal dialysis. *PLoS One*, 11(12), e0166470.

<sup>176</sup> Mitchell, A. J. (2013). The Mini-Mental State Examination (MMSE): an update on its diagnostic validity for cognitive disorders. *Cognitive Screening Instruments: A Practical Approach*, 15-46.

<sup>177</sup> Duara, R., Loewenstein, D. A., Greig-Custo, M. T., Raj, A., Barker, W., Potter, E., ... & Potter, H. (2010). Diagnosis and staging of mild cognitive impairment, using a modification of the clinical dementia rating scale: the mCDR. *International Journal of Geriatric Psychiatry: A Journal of the Psychiatry of Late Life and Allied Sciences*, 25(3), 282-289.

<sup>178</sup> Woolf, C., Slavin, M. J., Draper, B., Thomassen, F., Kochan, N. A., Reppermund, S., ... & Sachdev, P. S. (2016). Can the clinical dementia rating scale identify mild cognitive impairment and predict cognitive and functional decline?. *Dementia and Geriatric Cognitive Disorders*, 41(5-6), 292-302.

the 3-MS, MoCA, or CDR—adequately covers the complete cognitive domains specified by DSM-5-TR.<sup>179</sup> The DSM-5-TR provides a table of neurocognitive domains included in the diagnostic criteria of major neurocognitive disorder (Table 1 under the *Neurocognitive Disorders* section). All of these domains include examples of assessments in each area, and all examples are neuropsychological tests.<sup>180</sup>

Dr. Carney concluded by stating, “In my medical and professional opinion, Judge Newman demonstrated no substantial emotional, medical, or psychiatric disability that would interfere with continuation of her longstanding duties as a Judge in the U.S. Court of Appeals.”<sup>181</sup> In my opinion, Dr. Carney’s examination of Judge Newman did not include comprehensive and reliable cognitive tests appropriate for Judge Newman’s educational attainment, and Dr. Carney’s conclusion is based on insufficient and incomplete information.

#### **Conclusions from Section 2:**

Neither Dr. Rothstein nor Dr. Carney appropriately assessed Judge Newman’s cognitive abilities using comprehensive objective measures consistent with standard practice in determining potential cognitive impairment. Dr. Rothstein only administered part of a cognitive screening measure, and the measures administered by Drs. Rothstein and Carney assessed extremely basic information that does not address the concerns brought forth by Judge Newman’s colleagues and coworkers. Despite detailed accounts and corroboration among various members of the staff, these concerns were not adequately addressed by Drs. Rothstein, Carney, or Filler, and Drs. Carney and Filler prematurely and erroneously concluded that the presently available information did not warrant further testing and evaluation.

### **SECTION 3: CONCLUSIONS AND OPINIONS**

**SECTION 3.1:** The evidence and opinions put forth by Drs. Filler, Rothstein, and Carney were not consistent with standard practice in addressing possible cognitive impairment in a fitness for duty evaluation, and conclusions from these exams indicating that Judge Newman is not in need of further evaluation are not supported.

<sup>179</sup> Thabtah, F., Spencer, R., & Peebles, D. (2022). Common dementia screening procedures: DSM-5 fulfilment and mapping to cognitive domains. *International Journal of Behavioural and Healthcare Research*, 8(1-2), 104-120.

<sup>180</sup> American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). American Psychiatric Publishing.

<sup>181</sup> Carney, *Independent Medical Examination*, at 5.

Hon. Pauline Newman, a 97-year-old federal judge in the United States Court of Appeals for the Federal Circuit, is the subject of an investigation related to possible cognitive impairment that may affect her ability to carry out her work duties. Judge Newman declined to undergo evaluation in this context, but she provided opinions from physicians of her choosing that supported her ability to continue working without limitations or restrictions. This included a neurologist (Dr. Rothstein), a forensic psychiatrist (Dr. Carney), and a neurosurgeon and attorney with previous experience arguing cases in front of Judge Newman (Dr. Filler). None of the evaluations done on Judge Newman definitively rules out the presence of cognitive impairment. Procedures undertaken in these exams were—at best—appropriate for screening in a medical office but were not at all consistent with the level of scrutiny necessary for a fitness for duty evaluation involving potential cognitive impairment in a position of high responsibility. Most notably, Dr. Filler’s opinion was not based on standard, reliable, and accepted methods to diagnose cognitive impairment, did not address all possible causes of cognitive impairment, and ignored obvious signs of possible impairment that were not adequately addressed with Perfusion CT or cognitive screening measures.

In his report, Dr. Filler overstated the reliability, validity, and general acceptance of using Perfusion CT to rule out cognitive impairment and inaccurately asserted that Perfusion CT has replaced the role of neuropsychological testing as a standard part of the assessment of cognitive deficits. He made incorrect statements about the relative subjectivity of neuropsychological testing compared with Perfusion CT, and he neglected to mention how neuropsychological test scores are engrained in the very definitions of various cognitive disorders according to their diagnostic criteria. Dr. Filler relied on Judge Newman’s self-report and did not properly weigh the documented concerns of those around her, nor did he consider that other conditions aside from dementia could cause potential cognitive impairment. Dr. Filler only performed a brief interview and a Perfusion CT scan of Judge Newman, and his conclusions were premature and improper based on the information that he reviewed. Dr. Filler did not employ a single objective and widely accepted cognitive measure on Judge Newman, and his conclusion that no further evaluation or testing is needed is fundamentally flawed. There are standard and accepted methods to objectively assess cognitive impairment, and simply relying on his interpretation of a single brain scan is insufficient for the conclusions that he made. The many gaps in Dr. Filler’s opinion were not filled in by the reports from Drs. Rothstein or Carney, as there was still inadequate assessment of Judge Newman’s cognitive abilities. Despite detailed accounts and corroboration among various members of the staff, these concerns were not adequately addressed by Drs. Rothstein, Carney, or Filler, and Drs. Carney and Filler prematurely and erroneously concluded that the presently available information did not warrant further testing and evaluation.

I have no direct or indirect financial incentive for a particular determination, and compensation is not based on support or nonsupport of any opinion. I was paid at my standard rate of \$400 per hour to complete this evaluation. The conclusions, opinions, and recommendations contained in this report are based on information that was available at the time of this report’s preparation. Should additional information be forthcoming from any source, these conclusions, opinions, and recommendations are subject to review and revision.



Respectfully,



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Jonathan DeRight, PhD, ABPP  
Licensed Clinical Psychologist  
Board Certified in Clinical Neuropsychology



**APPENDIX A:**

**MATERIALS REVIEWED**

- Affidavit of [REDACTED] dated 04/19/2022
- Emails from [REDACTED] and [REDACTED] dated 01/30/2023 to 01/31/2023 (Exhibit 7)
- Declaration of [REDACTED] dated 04/06/2023 (including docket exhibits)
- Email from Chief Judge Kimberly A. Moore dated 04/19/2023 (Exhibit 1)
- Email from Judge Pauline Newman dated 04/19/2023 (Exhibit 2)
- Affidavit of [REDACTED] dated 04/20/2023
- Affidavit of [REDACTED] dated 04/24/2023
- Affidavit of [REDACTED] dated 04/25/2023
- Email exchange between Judge Pauline Newman and [REDACTED] dated 04/25/2023 to 04/27/2023 (Exhibit 5)
- Email from Judge Pauline Newman dated 04/27/2023 (Exhibit 3)
- Affidavit of [REDACTED] dated 05/03/2023
- Email exchange involving Chief Judge Kimberly A. Moore, [REDACTED], and Judge Pauline Newman dated 05/08/2023 to 05/09/2023 (Exhibit 4)
- Affidavit of [REDACTED] dated 05/09/2023
- Affidavit of [REDACTED] dated 05/18/2023
- Affidavit of [REDACTED] dated 05/19/2023
- Affidavit of [REDACTED] dated 05/23/2023 (including email exhibits)
- Affidavit of [REDACTED] dated 05/31/2023 (including docket exhibits)
- Affidavit of [REDACTED] dated 05/31/2023 (including email exhibits)
- Affidavit of [REDACTED] dated 06/01/2023
- Email exchange involving Chief Judge Kimberly A. Moore, Judge Pauline Newman, [REDACTED], [REDACTED] dated 06/06/2023 to 07/07/2023 (Exhibit 6)
- Affidavit of [REDACTED] dated 06/26/2023
- Declaration of Ted L. Rothstein dated 08/29/2023 (including attached exhibit)
- Order of the Federal Circuit Judicial Council in Case No. 23-90015 dated 09/20/2023
- George Washington University Hospital, Perfusion CT report dated 08/22/2024 (including 134 images)
- Report of Aaron G. Filler, MD dated 08/24/2024 (including attachments)
- 2024-8-24 Newman\_Pauline Eval from OneNote
- 2024-8-24 Newman\_Pauline Exam from OneNote
- Order of the Federal Circuit Judicial Council in Case No. 23-90015 dated 09/06/2024
- Affidavit of Aaron G. Filler dated 09/17/2024
- Regina M. Carney, MD, report of Independent Medical Examination of Pauline Newman, undated (including attached exhibits)
- Motion for Reconsideration of Judicial Council's Order of September 6, 2024 dated 09/25/2024

# JONATHAN DERIGHT, PHD, ABPP-CN

## CONTACT

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<b>Office</b>	1464 Ingleside Ave / McLean, Virginia / 22101
<b>Mailing</b>	1390 Chain Bridge Rd # 85 / McLean, Virginia / 22101
<b>Phone/Fax</b>	703-957-7300 (Office)    703-615-4896 (Cell)    571-418-0095 (Fax)
<b>Email</b>	deright@precisionnp.com

## EDUCATION

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<b>2014 – 2016</b>	<b>Postdoctoral Fellowship in Clinical Neuropsychology</b> The Johns Hopkins University School of Medicine Baltimore, Maryland
<b>2008 – 2014</b>	<b>Doctor of Philosophy in Clinical Psychology</b> Syracuse University (APA Accredited) Syracuse, New York
<b>2008 – 2011</b>	<b>Master of Science in Clinical Psychology</b> Syracuse University (APA Accredited) Syracuse, New York
<b>2004 – 2008</b>	<b>Bachelor of Science in Neuroscience</b> University of Rochester Rochester, New York

## LICENSURE & CREDENTIALING

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<b>2019 – Present</b>	<b>Diplomate, American Board of Professional Psychology: Clinical Neuropsychology</b> Certification Number: 8900
<b>2016 – Present</b>	<b>Commonwealth of Virginia, Licensed Clinical Psychologist</b> License Number: 0810005431
<b>2016 – Present</b>	<b>District of Columbia, Licensed Clinical Psychologist</b> License Number: PSY1001167
<b>2016 – Present</b>	<b>State of Maryland, Licensed Clinical Psychologist</b> License Number: 05722
<b>2021 – Present</b>	<b>PSYPACT</b> <b>Authority to Practice Interjurisdictional Telepsychology (APIT)</b>

**Temporary Authorization to Practice (TAP)**

Authorized to practice in Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, & Wyoming

**2016 – Present**

**National Register Health Service Psychologist**

Registrant Number: 55393

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**CLINICAL EXPERIENCE**

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**2020 - Present**

**President & Clinical and Forensic Neuropsychologist,**

Precision Neuropsychology, PLLC  
McLean, Virginia

**2016 – Present**

**Clinical and Forensic Neuropsychologist,**

Woodbridge Psychological Associates, PC  
McLean, Virginia / Woodbridge, Virginia

**2014 – 2016**

**Postdoctoral Fellow,** Division of Medical Psychology

Department of Psychiatry, Division of Medical Psychology  
The Johns Hopkins University School of Medicine, Baltimore, Maryland  
Director: Jason Brandt, Ph.D., ABPP-CN

**2013 – 2014**

**Predoctoral Intern,** Psychology Internship Program – Adult Track

Department of Psychiatry and Behavioral Sciences  
SUNY Upstate Medical University, Syracuse, New York  
Director: Roger Greenberg, Ph.D.

**2012 – 2013**

**Forensic Psychology Extern,** Central New York Psychiatric Center

New York State Office of Mental Health, Marcy, New York  
Director: Nichole Marioni, Ph.D., ABPP-FP

**2010 – 2013**

**Psychology Extern,** Psychological Services Center

Syracuse University Department of Psychology, Syracuse, New York  
Director: Kevin Antshel, Ph.D.

**2011 – 2012;**

**2009 – 2010**

**Neuropsychology Extern,** Neuropsychology Assessment Program

SUNY Upstate Medical University, Syracuse, New York  
Director: Dominic Carone, Ph.D., ABPP-CN

**2004 – 2007**

**Medical Assistant,** Emergency Department

Newark-Wayne Memorial Hospital, Newark, NY

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## ADDITIONAL TRAININGS

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- 2024**                    **AAFP: Evaluating Risk in Child Pornography Offenders**  
4-hour online course taught by Kostas A. Katsavdakias, ABPP-FP
- 2023**                    **AAFP: Assessment of Competence to Stand Trial**  
4-hour online course taught by Lori Hauser, PhD, ABPP-FP
- 2023**                    **Artificial Intelligence in Health Care**  
6-week online course through the MIT Sloan School of Management
- 2021**                    **Conducting Financial Capacity Assessments for Older Adults**  
10-week training course through Wayne State University
- 2021**                    **Evaluation of Defendant's Intent under Virginia Code §19.2-271.6**  
1-day training through the Institute of Law, Psychiatry and Public Policy, University of Virginia
- 2017**                    **Mental Competency in Immigration Review**  
**Sterling Medical/U.S. Department of Justice Initiative, Baltimore, Maryland**  
1-day training: Preparation for mental competency assessments to assist the DOJ Executive Office of Immigration Review (EOIR)
- 2016**                    **Adult Basic Forensic Evaluation required according to Code of Virginia §19.2-169.1 regarding evaluation of trial competence and §19.2-169.5 regarding evaluation of sanity at the time of the offense**  
5-day training through the Institute of Law, Psychiatry and Public Policy, University of Virginia
- 2016**                    **Conducting Mental Health Evaluations for Capital Sentencing Proceedings**  
2-day training through the Institute of Law, Psychiatry and Public Policy, University of Virginia

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## EXPERT QUALIFICATIONS

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Dr. DeRight is an approved forensic evaluator for the Commonwealth of Virginia, which allows him to be a court appointed evaluator in competency to stand trial and mental sanity at the time of the offense evaluations. His credentials and testimony have been accepted in every court or proceeding in which he has been offered as an expert, including the following:

*United States District Court:*  
*District of Columbia*  
*District of Maryland*  
*Eastern District of Virginia*  
*Western District of Virginia*

*Local Jurisdictions:*  
*Arlington County Circuit Court*  
*Alexandria Circuit Court*  
*Alexandria General District Court*

*Alexandria Juvenile and Domestic Relations Court  
Bedford County Circuit Court  
Fairfax County Circuit Court  
Loudoun County Circuit Court  
Louisa County Circuit Court  
Mecklenburg County District Court  
Prince William County Circuit Court  
Superior Court of the District of Columbia  
Stafford County Circuit Court*

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## TEACHING EXPERIENCE

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- 2024 – Present**                      **Clinical Professor of Psychology**  
*The Meltzer Center: Psychological and Community-based Services*  
The George Washington University
- 2020 – 2021**                      **Neuropsychology Extern Supervisor**  
*Precision Neuropsychology, PLLC*
- 2017 – 2018**                      **Neuropsychology Extern Supervisor**  
*Woodbridge Psychological Associates, PC*
- 2015 – 2016**                      **Neuropsychology Extern Supervisor**  
*Johns Hopkins University School of Medicine*
- 2015**                                      **MCAT Instructor**  
*Odyssey Program*  
Krieger School of Arts and Sciences, The Johns Hopkins University
- 2013, 2014**                      **Adjunct Professor**  
*Assessment in Counseling* (graduate course)  
Department of Counseling and Human Services, Syracuse University
- 2008 – 2010**                      **Teaching Assistant**  
*Foundations of Human Behavior* (undergraduate course)  
Department of Psychology, Syracuse University

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## RESEARCH EXPERIENCE

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- 2014 - 2016**                      **Research Fellow**, Division of Medical Psychology  
Department of Psychiatry  
The Johns Hopkins University School of Medicine, Baltimore, Maryland  
Principal Investigators: Jason Brandt, PhD, David Schretlen, PhD & Vidya Kamath, PhD
- 2008 – 2013**                      **Research Associate**, Psychophysiology Lab  
Department of Psychology

Syracuse University, Syracuse, New York  
Principal Investigator: Randall Jorgensen, PhD

**2010 – 2012**                      **Research Associate**, Translational Neuroscience Lab  
Department of Psychology  
Syracuse University, Syracuse, New York  
Principal Investigator: Stephanie Cacioppo, Ph.D.

**2006 – 2008**                      **Research Assistant**, Alzheimer’s Disease Lab  
Department of Brain and Cognitive Sciences  
University of Rochester, Rochester, New York  
Principal Investigator: Robert Chapman, Ph.D.

**2007**                                **Research Assistant**, Molecular Biology Lab  
Burnett School of Biomedical Sciences  
University of Central Florida, Orlando, Florida  
Principal Investigator: Ella Bossy-Wetzel, Ph.D.

**2004 – 2006**                      **Patient Enroller**, Emergency Department  
Strong Memorial Hospital, Rochester, NY

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### PEER-REVIEWED PUBLICATIONS

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Buchholz, A. S., **DeRight, J.**, Gerner, G. J., & Schretlen, D. J. (2023). Do “effort tests” really test effort? *Neuropsychology*, 37(1), 104–112. <https://doi.org/10.1037/neu0000865>

Kamath, V., Chaney, G-A., **DeRight, J.**, & Onyike, C.U. (2018). A meta-analysis of neuropsychological, social cognitive, and olfactory functioning in the behavioral and language variants of frontotemporal dementia. *Psychological Medicine*, Dec 6, 1-12.

**DeRight, J.**, Jorgensen, R.S., & Cabral, M. (2015). Composite cardiovascular risk scores and neuropsychological test performance: A meta-analytic review. *Annals of Behavioral Medicine*, 9(3), 344-357. doi:10.1007/s12160-014-9681-0

**DeRight, J.** & Jorgensen, R.S. (2015). “I just want my research credit”: Frequency of suboptimal effort in a non-clinical healthy undergraduate sample. *The Clinical Neuropsychologist*, 29(1), 101-117. doi:10.1080/13854046.2014.989267

**DeRight, J.** & Carone, D.A. (2015). Assessment of effort in children: A systematic review. *Child Neuropsychology*, 21(1), 1-24. doi:10.1080/09297049.2013.864383

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### BOOKS, CHAPTERS, AND OTHER PUBLICATIONS

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**DeRight, J.** & Vartkessian, E. (2022). Working with the Expert. In E. Kelley (Ed.), *Representing People with Dementia: A Practical Guide for Criminal Defense Lawyers* (pp. 141-153). American Bar Association. ISBN: 1639051325

**DeRight, J.** (2022). Essential Neuropsychology: A Concise Handbook for Adult Practitioners. *Springer Nature: Switzerland*. ISBN 978-3030853716

**DeRight, J.** (2019). History of “Frontal” Syndromes and Executive Dysfunction. In J. Bogousslavsky, F. Boller, & M. Iwata (Eds), *A History of Neuropsychology: Frontiers in Neurology and Neuroscience, Vol 44* (pp 100–107). Karger. DOI: 10.1159/000494957

**DeRight, J.** (2014). Detection of Dementia Risk in Primary Care: Preliminary Investigation of a Compositive Dementia Risk Score in Veterans. *Dissertations*, 142.

**DeRight, J.** (2011). Feedback, Task Demand, and Cognitive Test Performance in College Students. *Master's Thesis*.

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### CONFERENCE PRESENTATIONS

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Chaney, G.A., **DeRight, J.**, Aita, S., Onyike, C., & Kamath, V. (2017, February). *A meta-analysis of neuropsychological functioning, social cognition, and olfaction in the frontotemporal dementias*. Poster presented at the 45<sup>th</sup> International Neuropsychological Society Conference, New Orleans, Louisiana.

Bagger, J., **DeRight, J.**, & Brandt, J. (2017, February). *The Effect of Generation Gap on Informant Ratings using the IQCODE in a General Population Sample*. Poster presented at the 45<sup>th</sup> International Neuropsychological Society Conference, New Orleans, Louisiana.

**DeRight, J.** & Jorgensen, R.S. (2012, November). *Composite cardiovascular risk scores and neuropsychological test performance: A meta-analytic review*. Poster presented at the 32<sup>nd</sup> National Academy of Neuropsychology Conference, Nashville, Tennessee.

**DeRight, J.**, Jorgensen, R.S., Lewandowski, L., & Ortigue, S. (2011, November). *The effects of feedback, state anxiety, and gender on neuropsychological test performance*. Poster presented at the 31<sup>st</sup> National Academy of Neuropsychology Conference, Marco Island, Florida.

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### INVITED TALKS & APPEARANCES

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**DeRight, J.** & Peck, E.A. (2024, October). *Integrating artificial intelligence into clinical psychology*. CE course at the 2024 Fall Conference of the Virginia Academy of Clinical Psychologists, Virginia Beach, Virginia.

**DeRight, J.** (2024, June). *Responsibly using artificial intelligence (AI) to enhance the practice of clinical neuropsychology*. CE Workshop at the 2024 American Academy of Clinical Neuropsychology Annual Meeting, Scottsdale, Arizona.

**DeRight, J.** (2023, November). *Plenary: Neuropsychological testing in capital cases*. National Association of Criminal Defense Lawyers/Advancing Real Change Inc./Arizona Capital Representation Project BYOC Capital Defense Training. Orlando, Florida.

**DeRight, J.** & Shultz, E. (2023, June). *Selecting and effectively using mental health experts*. 2023 Holistic Defense and Leadership Conference. Baltimore, Maryland.

**DeRight, J.** (2023, March). *Application of clinical neuropsychology to the forensic setting*. Johns Hopkins Medical Psychology Seminar at Johns Hopkins Hospital.

**DeRight, J.**, Jackson, L., Cassis, A., Perme, D., & Gilbertsen, T. (2022, September). *Aging attorneys: A multi-disciplinary examination of the clinical, legal and professional challenges & benefits*. 2022 National Conference for Lawyer Assistance Programs. Washington, DC.

**DeRight, J.**, Jackson, L., Cassis, A., Perme, D., & Gilbertsen, T. (2021, September). *Our aging legal profession: Working with the benefits and the challenges*. Panel presentation to District of Columbia Superior Court Judges.

**DeRight, J.** & Shultz, E. (2020, November). *Selecting and Effectively Using Mental Health Experts*. National Alliance of Sentencing Advocates & Mitigation Specialists (NASAMS) Certificate Program.

**DeRight, J.**, Jackson, L., Cassis, A., Perme, D., & Gilbertsen, T. (2020, September). *Our aging legal profession: Working with the benefits and the challenges*. DC Bar CLE course.

**DeRight, J.** (2020, July). *The aging workforce: Distinguishing between normal and abnormal signs in the workplace.* PsyBar 2020 Webinar Series.

**DeRight, J.** (2020, May). *A Primer on Neuropsychology.* Advancing Real Change, Inc.

**DeRight, J.** (2018, April). *A primer on neuropsychological evaluations following stroke.* Sentara Northern Virginia Medical Center, Woodbridge, Virginia.

**DeRight, J.** (2017, February). *Beyond classification: Dimensional measurement of effort in neuropsychology.* James Madison University, graduate course in neuropsychological assessment.

Schretlen, D.J. & **DeRight, J.** (2016, June). *Reconsidering the clinical implications and assessment of cognitive effort in neuropsychology.* CE Workshop at the 2016 American Academy of Clinical Neuropsychology Annual Meeting, Chicago, Illinois.

**DeRight, J.** & Puente, A.N. (2016, February) *Differential diagnosis of dementia.* Kennedy Krieger Institute Neuropsychology Continuing Education Lecture Series, Baltimore, Maryland.

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### PROFESSIONAL ACTIVITIES

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<b>2025</b>	<b>Guest Editor</b> , <i>The Clinical Neuropsychologist</i> Special Issue on Artificial Intelligence
<b>2022 – 2024</b>	<b>Legislative Action and Advocacy Committee</b> , National Academy of Neuropsychology
<b>2019 – Present</b>	<b>Forensic Evaluation Oversight Panel Member</b> , Commonwealth of Virginia
<b>2015 – Present</b>	<b>Ad Hoc Peer Reviewer</b> <i>Archives of Clinical Neuropsychology, The Clinical Neuropsychologist</i> <i>Applied Neuropsychology, European Journal of Neurology, BMJ Open,</i> <i>Journal of Experimental Social Psychology</i>

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### PROFESSIONAL AFFILIATIONS

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<b>2009 – Present</b>	National Academy of Neuropsychology (NAN)
<b>2011 – Present</b>	International Neuropsychological Society (INS)
<b>2013 – Present</b>	American Academy of Clinical Neuropsychology (AACN)
<b>2018 – Present</b>	American Psychological Association (APA)
<b>2018 – Present</b>	American Psychology-Law Society (APA Division 41)
<b>2020 – Present</b>	Society for Clinical Neuropsychology (APA Division 40)

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### HONORS AND RECOGNITIONS

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<b>2016</b>	Early Career Psychologist Credentialing Scholarship
<b>2012</b>	National Academy of Neuropsychology Student Poster Award
<b>2008</b>	Shari & Joel Beckman Scholarship

**IN THE JUDICIAL COUNCIL OF THE UNITED STATES  
COURT OF APPEALS FOR THE FEDERAL CIRCUIT**

In Re Complaint No. 23-90015

**DECLARATION OF DR. JONATHAN DERIGHT**

I, **Dr. Jonathan DeRight**, declare pursuant to 28 U.S.C. § 1746 as follows:

1. I am a clinical psychologist licensed in Virginia, Maryland, and Washington, D.C. I am also a diplomate (i.e., Board Certified) in the specialty of Clinical Neuropsychology from the American Board of Professional Psychology.
2. I have prepared a report in this matter dated January 27, 2025, and along with it a copy of my curriculum vitae (CV).
3. Both my report and CV are true and correct to the best of my knowledge and the report presents my professional opinions.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: February 6, 2025

  
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Dr. Jonathan DeRight