Difficult Defense Tactic – and How to Fight It!

Countering the "Poor Historian" Attack

Part 2 of a Series

WHY IS YOUR CLIENT A POOR HISTORIAN?

Dr. Lichtenberg reports:

"In our last newsletter, we reviewed defense arguments that litigating accident patients have poor recall of their medical histories. This month, we will explore why clients are so often considered poor medical historians. It's not what the defense would have you believe!"

Why is your client a Poor Historian?

1. **For secondary or monetary gain? *Rarely***
2. **Because they have a poor memory? *Possibly***
3. **Because they have mental or behavioral disorders with associated psychological factors that affect everything they do? *Commonly***
4. **Because their complaints were ignored or not considered claim-related by a treating provider? *Commonly***
5. **Because the treating provider failed to document properly or was biased towards the insurance company or employer? *Commonly***
6. **Because of neuroplastic brain changes? *Frequently***

Last month, I listed several articles that noted that all patients under-report pre-existing conditions and over-report current symptomatology to some extent and claimants more so. I have found this to be true in practice as well. Why would people do this? What does your client gain by being or appearing to be a poor historian? Let's look at our list.

The Poor Historian Attack assumes clients consciously misrepresent their medical history for monetary or secondary gain. This is rarely the case. Occasionally, poor recall results in more money to the claimant, but more frequently it causes the claim to be contested and delayed, thus raising the medico-legal fees and reducing final payout.

Secondary gain, such as the ability to gain sympathy or avoid an unpleasant job or life activity, can be a component of any disease. Other examples of secondary gain are: the ability to withdraw from an unpleasant or unsatisfactory life role or activity; a “sick” role allows the patient to communicate and relate to others in a new, socially sanctioned manner; financial rewards associated with disability; drugs; avoiding a jail sentence; preferential or less hazardous work conditions or means of avoiding work altogether; and sympathy and concern of family and friends. Secondary gain is an external motivator; a highly interpersonal phenomenon which may or may not be recognized by the patient. If one is deliberately exaggerating symptoms for personal gain, then one is malingering. More often though, secondary gain is an unconscious psychological component resulting from symptoms and personality traits. These may, but need not be, recognized by the patient. Also, in the context of a person with a significant mental or psychiatric disability, this effect is sometimes called secondary handicap. It is rarely a motivator for a poor medical historian.

Frequently, patients believe that most pre-existing conditions are irrelevant to their current condition. Some providers unwittingly encourage this belief by ignoring that what has occurred is an aggravation of pre-existing problems. Most defense IME doctors do this routinely, even if the condition was previously asymptomatic. Their frequent tactic is to claim the pre-existing problem is the cause of the current complaints,

and then state the problem is non-claim related. Again, they claim this even if the pre-existing problem was asymptomatic. Clearly, records from previous providers are valuable tools in evaluating a claim, and can clarify an uncertain situation. It has been taught to physicians over and over that patient-reported history is a critical part of the diagnostic process; therefore, physicians must rely to a significant extent upon what the patient tells them.

Having complaints ignored can lead to symptom magnification. Symptom magnification is a conscious OR unconscious, usually self-destructive, learned pattern of behavior maintained through social reinforcement. It has reports and/or displays of symptoms, and controls the life circumstances of the sufferer. This is done consciously or subconsciously so that the healthcare provider will take them seriously.

Many providers consider symptom magnification as conscious malingering. Many providers historically have used Waddell's signs to detect malingering in patients with pain. They are wrong on both these ideas! Waddell's signs are a group of physical signs, first described in 1980 in *Spine*, and named for the author, Gordon Waddell. Waddell's signs may indicate non-organic or psychological component to pain. Clinically-significant Waddell scores are considered indicative only of symptom magnification or pain behavior, and have been misused in medico-legal contexts.

Dr. Waddell himself states clearly that Waddell's signs are a psychological cry for help, a psychological attempt to have their complaints be taken seriously. Although Waddell's signs can detect a non-organic component to pain, they do not exclude an organic cause. Waddell's signs are not considered a *de facto* indicator of deception for the purpose of financial gain. One or two Waddell's signs can often be found even when there is not a strong non-organic component to pain. Three or more are positively correlated with high scores for depression, hysteria and hypochondriasis on the Minnesota Multiphasic Personality Inventory. In a 2003 review, Fishbain[1], *et al*. stated that Waddell's signs do not reliably distinguish organic from psychological pain. In a 2004 review, Fishbain, *et al*.[2] concluded that there was little evidence for the claims of an association between Waddell signs and secondary gain and malingering. The preponderance of the evidence points to the opposite: no association. In 2010, a neuroanatomical basis of Waddell's signs has been proposed which argues that since the brain is organic, the term "nonorganic" should be replaced by a term put forward by Chris Spanswick in 1997, "behavioral responses to physical examination." These are best understood as neuroanatomical maladaptations to long-continued pain, and as Waddell and colleagues have stressed, do not indicate faking or malingering, but rather that there are psychosocial issues that mitigate against successful treatment.

The next newsletter article will discuss causes of poor memory and mental and behavioral confounders!

1 Fishbain, David; Brandly Cole, R. B. Cutler, John Lewis, H. L. Rosomoff, R. Steele Rosomoff (5 June 2003). "A Structured Evidence-Based Review on the Meaning of Nonorganic Physical Signs: Waddell Signs". Pain Medicine (American Academy of Pain Medicine)

2 Fishbain, David; R. B. Cutler, H. L. Rosomoff, R. Steele Rosomoff (November/December 2004). "Is There a Relationship Between Nonorganic Physical Findings (Waddell Signs) and Secondary Gain/Malingering?". Clinical Journal of Pain (American Academy of Pain Medicine)