

# Medicolegal Issues in Traumatic Brain Injury



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## KEYWORDS

- Physical medicine and rehabilitation • Psychiatry • Independent medical evaluation
- Neuropsychology • Neuroimaging • Medicolegal

## KEY POINTS

- Medicolegal expert testimony in cases involving TBI requires a different skill base than clinical practice.
- Psychiatrists involved in medicolegal work involving TBI cases must understand the ethical, legal, and business caveats that come with such undertakings and their disparities from standard clinical practice.
- The standards for assessment and diagnostic formulation in medicolegal work involving persons with TBI must meet current standards of community practice and opinion and medicolegal testimony (ie, Daubert standards).
- Psychiatric examiners must understand and appropriately use medicolegal terminology.
- When providing expert testimony in cases involving TBI, the psychiatric examiner must understand how to incorporate preinjury, injury, and postinjury information, the latter including but not limited to neurodiagnostics and neuropsychological testing, into their diagnostic formulations and opinions regarding apportionment and causality.

## INTRODUCTION

Physiatrists involved in the medicolegal assessment of persons with traumatic brain injury (TBI) have many challenges facing them including but not limited to (1) how to fully assess the causality, apportionment, and impact of the myriad impairments that may occur after such injuries, direct and indirect; (2) how to ensure that the examinee provides optimal effort and valid performance; (3) how to formulate opinions to

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provide the necessary assistance that the triers of fact in the case require; (4) how to strive to maintain neutrality and ethical practice in an adversarial environment ripe with nonobjective influences and potential for bias; and (5) how to provide a holistic biopsychosocial analysis of the case while acknowledging any limitations, as they may exist, in the data, analysis, and/or conclusions.

The formal medicolegal evaluation or so-called independent medical evaluation (IME) provides an opportunity for a nontreating physiatrist to perform an assessment of an individual for purposes of opining on a potential wide range of issues emanating from a claimed TBI. Within that context the physician must know how to take a thorough and relevant history, perform a relevant hands-on evaluation, review all neurodiagnostics (including neuropsychological and neuroimaging evaluations), and generate a report that addresses the claimed TBI related consequences (discussed later).

### CONTROVERSIES AND CAVEATS

Traditional IME training, regardless of the specialty organization responsible for said training, holds that there is no physician-patient relationship in the context of an IME.<sup>1</sup> In this context, the physician becomes the examiner and the person being assessed, the examinee. It should also be noted that an examiner-examinee relationship in the absence of a treating relationship would dictate that the examiner not share opinions regarding their examination findings and/or conclusions. The party who retained the examiner to conduct the IME should be the only person or persons receiving such information. Traditional training also dictates an absence of confidentiality in such a setting (ie, if the examinee tells you they murdered someone then you have the legal and ethical responsibility to report what was conveyed).<sup>1</sup> It is also important to remember that the IME document is privileged and should only be released to the requesting agency unless otherwise appropriately subpoenaed.

Some organizations' IME ethical guidelines run contrary to the espoused traditional practices.<sup>2</sup> For example, the American Medical Association (AMA) has stipulated that there is a limited patient-physician relationship in the context of an IME.<sup>3</sup> Additionally, the AMA code further edified that one had to maintain patient confidentiality as outlined in Opinion 5.09 dealing with IMEs, which specifically stipulates that confidentiality is to be maintained as with any other "patient" except as "required by law."<sup>4</sup> The AMA ethics code further directs physicians involved in IMEs to "disclose fully potential or perceived conflicts of interest," noting: "The physician should inform the patient about the terms of the agreement between himself or herself and the third party, as well as the fact that he or she is acting as an agent of that entity." The authors have concerns about stipulating that one is an agent for the retaining party given the implications of advocacy for said party when one's role by definition should be neutral as a nonadvocate for any side involved in the litigation.

Physiatrists are often challenged to apply general clinical ethics to unfamiliar medicolegal situations. Many organizations offer their own versions of board certification. The criteria for attainment of these certifications vary from merely paying a fee, to a requirement for formal training, practical experience, and written and/or oral examination. Board certification and at a minimum board eligibility should serve as the foundation for providing any medicolegal testimony. Further subspecialty certifications, such as the American Board of Physical Medicine and Rehabilitation Brain Injury Medicine Certification can further bolster one's credentials if testifying on TBI-related cases. Other organizational certifications may be of value in the context of learning IME practice nuances but one should carefully investigate the organization's reputation and scope of training, and membership and certification requirements. Experience,

training, and additional credentials including publication and speaking record can serve an expert well in terms of knowledge base and ultimately being accepted by the court to meet “expert” criteria.

The potential liability that an examiner may have for opinions expressed in the context of the examination and/or for any real or claimed psychological or physical injury that the examinee may have sustained in the examination process is rarely considered by medical practitioners. Clinicians are not immune to legal action for work performed in the context of such evaluations and should ensure that their medical malpractice insurance specifically covers all dimensions of their medicolegal practice. Practitioners must also realize that IMEs are generally viewed by State Medical Boards as constituting the practice of medicine; therefore, performing IMEs or testifying in states where one is not licensed puts one at risk for being charged and even convicted of practicing medicine without a license.

#### **THE MEDICOLEGAL EXAMINATION: AN OVERVIEW**

The general requirement for ensuring ethical conduct in any form of medicolegal evaluation is rendered even more imperative when confronted by the complex, often subtle range of impairments and associated disability that may occur after TBI, particularly when more mild. The evaluator must be cognizant of the relative attribution of postinjury impairment to the TBI itself versus comorbid conditions including but not limited to posttraumatic psychological, musculoskeletal, and/or peripheral neurologic disorders. It should be understood that in most cases the IME occurs as a one-time event, thereby necessitating as complete an assessment as feasible in the context of the time permitted, which often is limited by opposing counsel and/or the court. Setting the assessment standards high by adhering to ethical conduct while using evidence-based assessment methodologies that meet current consensus practice standards should be every expert psychiatrist’s goal.<sup>5</sup>

Evaluators are expected to provide equal measures of respect to the examinee including courtesy, dignity, and fairness and spend adequate time in the assessment process. Certain forms of assessment may need to be provocative, either psychologically or physically, to evoke symptoms and/or signs relevant to making diagnostic formulations in a case. In this context, testing should always be performed for symptom and sign validity, performance validity, effort, and response bias to ensure that the presentation and testing results accurately reflect the examinee’s condition. Experts should keep in mind that depending on the evaluation circumstances examinees may overreport, underreport, and accurately report their symptoms and some may do a combination of the aforementioned, consciously and/or unconsciously.

In common with the judiciary, the duty of impartiality is owed equally to all litigating parties. It is the evaluator’s task to conduct the evaluation in a fair manner and to present the results fully and objectively without advocacy for any party involved. The expert, first and foremost, remains a physician and should follow the Hippocratic Oath at all times.

#### **MEDICOLEGAL TERMINOLOGY**

Several terms and phrases are unique to the world of clinicolegal practice that should be familiar to anyone who serves as an expert witness.<sup>6</sup>

- **Aggravation:** a permanent worsening of a pre-existing impairment/condition.
- **Apportionment:** the act of assigning responsibility of a particular event or injury to a certain proportion or percentage of an examinee’s particular impairment.

- Causality: the act of relating a particular consequence, such as an impairment, to a specific event or set of events in time.
- Exacerbation: a temporary worsening of a pre-existing impairment/condition.
- Maximum medical improvement: therapy phraseology that emanates from Worker's Compensation literature in the AMA Guides to Evaluation of Permanent Impairment, the meaning of which has evolved over time and remains consensus as opposed to evidence based.<sup>7</sup> In the sixth edition of the Guides to Evaluation of Permanent Impairment, it is conceptualized as "a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected change." It is important to note if there is potential for future improvement and/or decline depending on the nature of the specific injury and impairments (ie, poorly controlled epilepsy).
- Medical probability: the statistical likelihood that the medical event in question is more likely than not (greater than 50%) going to occur or occurred because of a particular event, which is different from the traditional levels of "significance" used in hypothesis testing (ie, .01 level of significance).

### ETHICAL CAVEATS

The American Academy of Physical Medicine and Rehabilitation published a white paper with recommendations for expert witness testimony.<sup>8</sup> There has been no updated version of this document published since its initial release. This document indicates that the expert witness should serve to educate the court as a whole, rather than representing one side or the other, independent of which side retained the expert. The ultimate test for accuracy and impartiality is whether reports or testimony could be presented without alteration for use by either the plaintiff or the defendant.

Three additional recommendations are emphasized: (1) identification of opinions that are personal and not necessarily held by other physicians, (2) making a clear distinction between medical malpractice and medical maloccurrence when analyzing case evidence, and (3) willingness to submit transcripts of depositions and/or courtroom testimony for peer review.

The role of the evaluator should be passive in relationship to the evaluatee and his/her family. The evaluator neither seeks nor accepts any duty of care, and must explicitly, firmly, and unambiguously discourage any expectation of or request for care. Avoiding conflicts between differing professional roles is equally important given the potential for compromising objectivity and credibility.<sup>9</sup>

The main ethical caveats in the context of providing testimony on cases involving TBI should include the following:

- Substantive experience in the area in which one is to testify
- Limitation of testimony to one's sphere of medical expertise
- Professional conduct, including language, at all times
- Maintaining a nonadvocacy position
- Provision of findings that are favorable and unfavorable with regards to the case in question
- Avoidance of mixing expert roles
- Avoidance of adversarial posturing
- Address the science behind the opinions and not those persons providing the opinions (ie, avoid denigration of fellow professionals)
- Avoid scenarios with potential conflict of interest (by perception or in reality)
- Remain objective and unbiased at all times

- Charge for your time as an expert not for the activity you are engaged in
- Save all notes and testing generated during the IME

#### REVIEW OF EXPERT ROLES IN MEDICOLEGAL CASES

Relevant to physicians and other professionals, Blau<sup>10</sup> identified three different and conflicting roles for professionals working in medicolegal settings: (1) treating doctor, (2) expert witness, and (3) trial consultant. Great caution should be taken to avoid engaging in more than one of these roles in a particular case; however, treating doctors are often asked by lawyers to serve as experts to save on expenses. Each role has a unique set of responsibilities that, because of conflicting expectancies and pressures, increases risk of compromising objectivity. Every effort should be made to avoid placing the practitioner in a conflictual relationship with their patient and with their own practice ethics because one must be an advocate for their patient and cannot therefore be “neutral” as a treater/expert.

A further role existing in some circumstances is that of “peer or case reviewer.” This professional is retained to review the case evidence without direct assessment of the evaluatee (evidentiary review), and/or to critically evaluate the opinions in the case. Not all clinicians are comfortable with performing a strictly evidentiary review and offering expert opinions about a claimant or a peer based solely on documentation without interview or direct evaluation. Some practitioners stipulate that their peer review work product should be used only for internal review purposes and not proffered for medicolegal purposes.

#### INDEPENDENT MEDICAL EVALUATION TIPS FOR TRAUMATIC BRAIN INJURY CASES

- Always obtain a retention letter and a signed retention/consultative agreement.
- Always make sure you request clear documentation as to why you are being retained and what specifically you are being asked to do.
- Establish ground rules with all sides before the examination/evaluation.
- Have the examinee sign a consent for evaluation, photography, and videography, as relevant, and a document stipulating the expectancies from them as the examinee (ie, be honest, cooperative, and put forth full effort).
- Strive to use standardized, objective, normed, and generally accepted evaluation tools/examinations in the context of the evaluation including tests of effort; response bias; and sign, symptom, and performance validity.
- Always request an opportunity to talk with corroboratory sources.
- Avoid third-party observers given their potential to denigrate examinee performance and when not possible acknowledge the potential negatives of same in the IME report.<sup>11,12</sup>
- Avoid pejorative language in the context of direct assessment and/or in the report itself.

#### THE INDEPENDENT MEDICAL EVALUATION EXAMINATION

Every effort should be made to optimize examinee performance during an IME. These evaluations can be anxiety provoking particularly when seen by an expert physician retained by opposing counsel. It is therefore of utmost importance to make sure the examinee knows that the examiner is there to advocate for the truth and not for any party involved in the litigation process. Making sure that there is consent given for the evaluation by the examinee or their guardian and that the examinee and/or guardian fully understand what is involved in the evaluation process should be a

priority from the first moments of the encounter. Examinees should be educated to ask questions if they are unclear on any directions during the examination and to inform the examiner if they require a break, need to take medications, or are having discomfort because of an examination procedure.

The examiner should make every effort to obtain as complete a history as possible from the person being assessed and corroboratory sources. The latter is often not permitted by opposing counsel when conducting defense examinations but remains no less critical in that context. The history taken must include preinjury, injury, and postinjury information. It is equally imperative to clarify all potentially relevant comorbidities, especially social/situational stressors that may or may not be injury related, nonrestorative sleep, pain issues, over-the-counter and prescription medication prescription history, drug treatment response history and side effects, and any substance use/abuse, among other historically relevant points. The examinee and appropriate corroboratory sources should be interviewed to determine what the claimed impairments are deemed to be by them that are consequential to the TBI being litigated. As much information as possible should be obtained about the initial injury and details regarding same, timing of symptom and sign onset, changes over time, response to treatment, compliance with said treatment, and current status and functional limitations. Information regarding functional limitations with activities of daily living (basic and higher level), mobility, communication, psychosocial function, sexuality, cognition, behavior/personality, avocational pursuits, and work should all be explored.<sup>1,13,14</sup>

A complete elemental neurologic examination should be performed including standardized and normed measures of cognitive and behavioral function. Any medicolegal assessment should consider for effort, response biases, and sign and symptom validity.<sup>1,15,16</sup> Examiners should also use relevant assessment tools that address functional abilities germane to the examinee's level of neurologic impairment, such as the Functional Independence Measure, Disability Rating Scale, Coma Recovery Scale Revised. For cases involving mild TBI, the expert should be aware of current forensic neuropsychiatric issues germane to this group of patients.<sup>17,18</sup> The examiner should review all questionnaires and tests to make sure they are fully completed.

#### **THE INDEPENDENT MEDICAL EVALUATION REPORT**

The report should be presented in an organized and systematic fashion including the referring source, nature of evaluation, all records reviewed, complete delineation of testing performed, and results from same (for complete transparency some examiners even include their handwritten notes).<sup>19</sup> Box 1 provides the suggested areas to be included in any IME report.

#### **EXPERT WITNESS TESTIMONY: PREPARATION AND PERFORMANCE**

There are several rules that experts should adhere to with regard to providing testimony when serving as an expert witness.<sup>20,21</sup> These rules include the following:

- Always be prepared; review relevant documentation as needed including your notes and report before providing any testimony.
- Always expect the unexpected question (just because a question is asked does not mean you need to answer it if it is not relevant to your testimony; ie, you can refuse to answer or take the fifth).
- Be honest and if you do not know something acknowledge so.
- Be a teacher (that is educate the triers of fact on the matters of relevance in the case).

**Box 1****IME content in a TBI case**

Demographic details including name, address, birth date, age, sex, handedness, and social security number/license number

Referral source: name, position, company, address, telephone, fax, and email

Party responsible for payment; may be different than party that retained

Type of report (ie, IME, peer review, consultant report)

Documents requested and reviewed

Documents requested but not received at time of report issuance

History of present illness (per records and per examinee and corroboratory sources)

Past medical and mental health history

Family medical history

Psychosocial history including any history of abuse, substance use/abuse, marital history, counseling, and hobbies among other areas of inquiry

Educational history including any history of learning disability, school problems (eg, being held back, behavioral issues, failing grades)

Vocational history including current and prior jobs, physical requirements of same, and duration of employment

Military service history including duration, status of discharge, and rank achieved

Legal history, including civil and criminal, as applicable

Review of systems

Assessment including physical examination (neurologic, musculoskeletal, and related relevant systems based on injury history) and cognitive behavioral testing with inclusion of positive and negative findings and response bias, effort, and symptom, sign, and performance validity assessment results

Diagnostic impressions with identification of which are injury related, not injury related, versus possibly injury related

Maximum medical improvement status

Impairment ratings as requested (generally based on AMA Guides to Evaluation of Permanent Impairment)

Prognostic opinions regarding general status as related to TBI and as necessary broken down into specific impairment-related prognoses and return to work prognosis

Causality and apportionment opinions

Risk and restrictions as related to the injury/TBI in question

Life expectancy or median survival time opinions as requested/relevant

Recommendations for treatment or further diagnostic studies

Edification clauses focusing on caveats regarding the report content, implications, liability, and potential for altering opinions if additional information is provided

Relevant appendices

- Always ask to read your deposition, whether discovery or de bene esse.
- Always dress and present professionally for any legal proceeding.
- Avoid head nods, always speak clearly, use proper grammar, project your voice, and avoid being monotone.

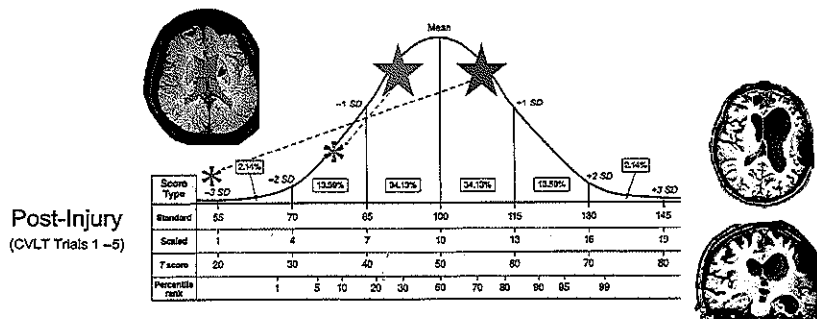
- If you do not understand the question say so and/or ask for it to be rephrased.
- If you misspeak, correct yourself and remember your answer is not being timed, so think before you speak.
- Only answer the question asked, no more, no less unless you believe you are being set-up by opposing counsel, then elaborate only to clarify (if the other attorney needs you to say more they will ask you).
- Avoid becoming argumentative or confrontational with opposing counsel.
- Only testify on the basis of medical probability unless otherwise asked.
- Decline answering hypotheticals if you believe your answer will be used to confound your expert opinion.
- Always be prepared to provide a rationale and scientific explanation that meets general consensus standards in your field for each and every expert opinion you have provided.

**NEUROPSYCHOLOGICAL ASSESSMENT: A PHYSIATRIC PRIMER**

Cognitive and behavioral functioning may be altered in a variety of ways following a significant TBI. As outlined in Jason R. Soble and colleagues’ article, “Neuropsychological Evaluation in TBI,” in this issue, neuropsychology has developed and standardized methods to measure the neurobehavioral and neurocognitive sequelae associated with TBI. For the physiatrist needing to render a medicolegal opinion, it is important to know how to extract the most meaningful and objective information from a neuropsychological evaluation to render opinions regarding cognitive-behavioral impairment and implied disability.

Neuropsychology is built on the foundation comparing standardized test performance of the individual with a large normative sample.<sup>22</sup> Typically, an examinee’s test score is referenced to a bell curve distribution as shown in Fig. 1. By plotting this information, the clinician can visualize how a particular cognitive score or behavioral measure compared with other individuals. As shown in Fig. 1, neuropsychological test scores typically are referenced as standard (mean = 100; standard deviation [SD] = 15), scaled (mean = 10; SD = 3), T- (mean = 50; SD = 10), and/or percentile scores.<sup>22</sup> There are several approaches to interpreting a low score:

- Deficit model: considers low scores that fall below the average or “normal” range (at or below 1 SD) as potentially reflecting impairment.



**Fig. 1.** Bell curve and the interpretation of neuropsychological test results. Red, severe TBI; blue, mild TBI; asterisk, actual postinjury memory score; star, baseline estimate memory; SD, standard deviation.



- Discrepancy model: considers low scores to reflect impairment if they substantially deviate from inferred premorbid ability based on educational testing and records, employment history, and anecdotal information.
- Deficit pattern model: assumes the clustering of where maximum performance occurs on various tests, or using the best performance scores permits estimating a general level of premorbid functioning and where deficits reside.

Most neuropsychologists use a combination of these approaches and other methods, but all have limitations.<sup>22,23</sup>

#### Limitations of Neuropsychological Test Findings in a Medicolegal Setting

Regardless of the approach used a major limitation of neuropsychological assessment is that currently it is not done in a naturalistic setting, which hampers the so-called ecological validity of neuropsychological test results.<sup>24-28</sup> For neuropsychological tests to be standardized they always have to be administered in the exact same manner, using the same questions, prompts, and queries for each test item. Given this artificiality and limits of the assessment setting, it becomes immediately apparent that some neuropsychological measures may inadequately tap real-world questions and ability to function. This is where reliable work-place information and/or input from family and colleagues who knew the person before and after injury may be instrumental.

Additionally, there is the issue of whether a patient is exhibiting maximum effort in performing the task. Underperforming on a mental measure could be interpreted as a deficit, when in fact there is not an impairment. Unfortunately, this is a complicated issue with no universal solution. In the context of a medicolegal case involving TBI measures of symptom validity testing (SVT) and performance validity testing (PVT) should be administered and specifically commented on within the neuropsychological report because whenever litigation is present the specter of secondary gain is always present. The Institute of Medicine has provided overview on this topic (<http://nationalacademies.org/hmd/Activities/SelectPops/TestingSSADisability.aspx>). A major interpretative challenge associated with SVT and PVT measures is that brain injury alone may alter neurologic function associated with task engagement, motivation, and task performance such that neurologically impaired patients may "fail" these measures because of the brain injury and not because of overreporting and/or underperforming as an attempt to manipulate the assessment.<sup>29</sup>

Possibly the biggest problem forensically in neuropsychology is that there is no agreed on neuropsychological test battery uniformly used.<sup>30</sup> Often, this merely provides legal fodder for active debate on which tests were used and their appropriateness for assessing the inferred impairment, if present. Legal debates like this become confusing to the triers of fact as to how different neuropsychologists can examine the same patient, ostensibly using the same or similar neuropsychological assessment instruments, yet have diametrically opposite viewpoints. Legal debates about these limitations of neuropsychological test findings can turn into endless legal tit-for-tat arguments (eg, just as they can with medical expert opinions on such issues as prognosis and life expectancy).

How can greater objectivity within a medicolegal setting be brought to the trier of fact? Fortunately, given twenty-first century neuroimaging technology, neuropsychological test findings are integrated with neuroimaging and other elements of the overall medical assessment, thereby lessening the ambiguity of clinical correlation between brain injury and outcome. Because neurocognitive and neurobehavioral sequelae may occur as a consequence of multifaceted factors, it is the author's recommendation that the best use of neuropsychological findings is integrated with a psychiatric

approach and contemporary neuroimaging findings. Indeed, it is our recommendation that no conclusions can be made from neuropsychological test findings without this kind of integration.

#### **NEUROIMAGING AND NEUROPSYCHOLOGY: MEDICOLEGAL IMPLICATIONS FOR THE PHYSIATRIST**

Computed tomography is most commonly performed acutely with MRI more commonly performed as a follow-up procedure.

Because frontotemporal and deep white matter neuropathologic changes associated with TBI are the most likely abnormalities to be identified by neuroimaging studies, abnormalities within these regions tend to relate to slowed processing speed, altered attention/concentration including working memory, along with impairments in episodic memory and/or executive functioning.<sup>22</sup> Damage to these regions may also alter emotional regulation without associated cognitive impairment. Given these relationships, in the TBI patient with positive neuroimaging identified by accepted and objective standards and impairments in one or all of those domains, clinical correlation can be established.

Unfortunately, a noncomplicated mild TBI case with negative imaging including MRI at follow-up constitutes the most challenging type of case. Neither neuroimaging or neuropsychological assessment as stand-alone procedures can diagnosis this condition. Furthermore, changes in mood, sleep disorder, chronic pain, and related medical conditions including posttraumatic stress disorder and depression may produce cognitive and neurobehavioral changes similar to what occurs after TBI, particularly when mild. As such, test findings from a neuropsychological assessment alone without other information cannot diagnosis mild TBI. The history and circumstances of the event that injures the individual, their initial signs and symptoms, and the post-injury course are the factors that define whether a TBI occurred, not some test score on a neuropsychological measure. Additionally, headache, lethargy and fatigue, apathy, and related symptoms have no specific neuropsychological assessment method for evaluation but may occur in the patient with TBI.

The physiatrist evaluating the patient after mild TBI should expect that the neuropsychological test results will generally be either subtle or nondescript and unremarkable. When it is clear that significant trauma has occurred, neurologic signs and/or symptoms have ensued consistent with a concussive brain injury, and SVT/PVT assessments are all passed, yet, the patient persists in having neurosymptoms, they may be part of the ill-defined group of patients with persistent postconcussion symptomatology (see Blessen C. Eapen and colleagues' article, "Disorders of Consciousness"; and Rebecca N. Tapia and Blessen C. Eapen's article, "Rehabilitation of Persistent Symptoms After Concussion," in this issue).

#### **THE FUTURE OF NEUROPSYCHOLOGY AND NEUROIMAGING IN PHYSIATRIC EXPERT TESTIMONY**

In the presence of traditionally identified pathology, these techniques can provide more descriptive quantitative information about the pathology.<sup>31</sup> However, it takes time for these techniques to be more routinely incorporated into diagnostic decision making. As outlined by a position statement from the American Society for Neuroradiology, there are emerging guidelines on how these advanced neuroimaging methods can be used in the medicolegal setting.<sup>32</sup> As these techniques evolve they hold promise to provide the physiatrist with additional biomarker information about the injury to the brain and how it relates to medical prognosis and outcome in TBI.

## PRACTICAL RECOMMENDATIONS

Interpreting psychological test results has long been criticized as speculative when it comes to explaining behavior. Major university and medical center-based training programs in clinical neuropsychology emphasize objective and concise report writing with conclusions summarized in a few pages. Although there may be a considerable amount to discuss about a case, in TBI the questions are straightforward. Did this patient sustain a TBI? Are there neuroimaging findings consistent with having sustained a TBI? Can the neuropsychological findings be interpreted within the context of what neuroimaging and the medical history reflect? Are there residual deficits that can be reliably demonstrated in the test findings that interfere with the patient's activities of daily living? Answers to these questions can be accomplished with brevity in report writing.

Stuss<sup>33</sup> offered the following six principles in the neuropsychological interpretation of the TBI patient, paraphrased as follows:

- Everything must make sense
- The severity of TBI must be defined by the acute injury characteristics
- Symptoms gradually improve
- Rules of logic must always apply
- Decisions should be based on “competent, multidisciplinary, longitudinal research”
- The evaluation be conducted knowledgeably with appropriate assessment metrics

Following these guidelines should lead to appropriate interpretation of test findings.

## SUMMARY

Medicolegal expert work is rife with challenges across several spheres including legal, ethical, and medicolegal. The physiatrist who engages in such work must take the time to ensure an intimate knowledge of these various areas to not only conduct quality work but also to ensure provision of unbiased opinions that will truly assist the triers of fact in advocating for appropriate and fair settlement. In that context, physiatrists must also understand that they have potential liability on several different levels in the context of conducting this type of work including having the potential to be sued or charged with practicing medicine without a license. Profitable as such work may often be, clinicians need to be prepared to be put “under the microscope.” The process, by its nature, is often adversarial, stressful, and time consuming. Medicolegal expert work requires a high level of sophistication in terms of methodology, assessment techniques, diagnostic formulation skills, and written and oratory skills that is different from those required in daily clinical practice.

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