

Difficult Defense Tactic – and How to Fight It!

Countering the "Poor Historian" Attack

Part 3 of a Series

Dr. Lichtenberg reports:

"In the first newsletter, we reviewed defense arguments that litigating accident patients have poor recall of their medical histories, usually under-reporting pre-existing conditions and over-reporting current symptomatology. In the second newsletter, we explored secondary gain, Waddell's signs, and symptom magnification as reasons why clients are so often considered poor medical historians, yet these are usually incorrect analyses and therefore false arguments.

So, again, what does your client gain by being or appearing to be a poor historian? Let's look again at our list of causes.

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 affects 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***

So now let's look at poor memory and mental and behavioral disorders with associated psychological factors as causes of being a poor historian.

Cause #2: Because they have a poor memory. *Possibly.*

1. It is common in my practice of pain patients for people to forget or remember incorrectly parts of their history, including specific incidents and dates. It is a well-known fact that virtually all patients, not just claimants, do not have excellent recall of all their problems, especially details.

2. Many claimants have been taking pain meds, narcotics, neuropathic meds, antidepressants, muscle relaxers, anti-anxiety meds, sleeping pills, and other central nervous system acting medications, all of which can contribute to incorrectly recalling parts of their history.

3. Claimants who have severe pain or multiple areas of pain, especially chronically or long-term, may only recall their worst episodes of pain, ignoring or forgetting less severe episodes. In any claim, when the physician asks them about other episodes of pain, the claimant may only recall the very severe pain, as a burning radiculopathy, and may be so used to chronic pain which frequently flares up to moderate or moderately severe, that the recall of pain events is not good.

4. Therefore the patient is just not remembering all events exactly as they occurred in relation to exact time, date, and place.

Cause #3: Because they have mental or behavioral disorders with associated psychological factors that affects everything they do? *Commonly.*

A number of studies demonstrate a link between impaired physical function and psychological factors and cognitive function (which includes memory), including pain, coping, psychological well-being, depression and anxiety

One study used functional MRI (fMRI) to show that chronic pain can alter brain circuitry.

Another study noted correlations between changes in mood on the one hand and changes in pain response and pain tolerance on the other hand. It concluded that, in chronic pain patients, negative mood increases self-reported pain and decreases tolerance for a pain-relevant task, with positive mood having the opposite effect.

Here is a cut and paste from a defense IME Drs. report: The diagnosis is chronic pain disorder with associated psychological factors and general medical condition. As noted, she is an unreliable historian. In my opinion, her perception of her pain is far out of proportion to the actual situation, medically known as symptom magnification.

To counter this claim, per the American Medical Association Guides to the Evaluation of Permanent Impairment, it states that chronic pain syndrome is frequently used to describe an individual who is markedly impaired by chronic pain with substantial psychological overlay and consists of an abnormal illness failure that consists mainly of excessive adoption of the sick role. It does note that peripheral and central sensitization do occur, and that the patient perceives the pain is real. In the section on pain, behavioral confounders, it notes that prospective studies consistently report that onset of disabling pain is highly associated with factors such as job dissatisfaction, lack of support, work stress, perceived inadequacies of income, associated issues such as social and economic factors and language problems.

Again, most Defense IME Drs and many treating providers (especially those who get most of their referrals from insurance companies or employers) ignore or just never ask about the psychological problems. If a claimant IME or the treating provider always asks about these psychological issues, they can be identified early, when treatment is much more likely to be effective.

My next newsletter will address the strong bias of the treating provider or defense IME towards the insurance company or employer, and then the Dr. ignoring the complaints, not considering them claim-related, or failing to document complaints properly.