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Hot Topics in Workers Comp **Complex Regional Pain Syndrome** **“Concussion”**

Posttraumatic Stress Disorder
Preventing Harm from Surgery and
Pain Management
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BARTHNeuroScience



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Resolve Claims through

FACTS

Rather than Expert Opinion

- Mayo Clinic – Impairment Without Disability
- Florida Office of Judges of Compensation Claims

Overview



- **Opinion-based testimony from experts is extensively corrupting and complicating legal claims, and consequently compromising the justice system.**
- **The focus on opinions is unnecessary and unjustified.**
- **The corrupting influence of opinions can be combatted through a focus on FACTS**

Davidson TM et al.
Evidence-Based Medicine (EBM): The
(Only) Means for Distinguishing
Knowledge of Medical Causation from
Expert Opinion in the Courtroom.
*Tort Trial and Insurance Practice Law
Journal*, 2012, Volume 47, Issue 2



***ABA publication on
scientific findings (facts) as a
better basis for legal decisions
than doctors' opinions***

ABA publication on
“Evidence Based Medicine”



*“Current system...is
primitive, crassly subjective,
and prone to exploitation, if
not actual corruption”*

ABA publication on
“Evidence Based Medicine”



***“courtroom medical
experts invariably have
opposing opinions”***

ABA publication on
“Evidence Based Medicine”



“expert opinion proffered in
court does not yield
knowledge of medical facts;
the best evidence does”



Facts of relevance to
Complex regional pain syndrome
And
Reflex sympathetic dystrophy



AAOS
AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS
*Your Source for Lifelong
Orthopaedic Learning*

**19th Annual AAOS Workers'
Compensation and Musculoskeletal
Injuries: Improving Outcomes with
Back-to-Work, Legal and
Administrative Strategies**
Volume 1 - Friday

*November 3-5, 2017
Las Vegas, NV*

*J Mark Melhorn, MD
Charles N. Brooks, MD
Course Directors*

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**Complex Regional Pain
Syndrome:
A fact-based definition
Published repeatedly by
the American Academy
of Orthopaedic
Surgeons
2014, 2015, 2016, 2017**



CRPS: A fact-based definition

**Published by the
American Academy of Disability
Evaluating Physicians
(Martin, 2015)**

**Also addresses legal
considerations, such as the issues
which prevent a claim of CRPS
from satisfying Daubert
standards.**

Complex Regional Pain Syndrome What Is the Evidence?

A faint, stylized illustration of a hand holding a stethoscope, positioned behind the authors' names.

Douglas W. Martin, MD
Robert J. Barin PhD
Trang H. Nguyen, MD, PhD
David C. Randolph, MD, MPH, PhD
James B. Talmage, MD
Russell L. Travis, MD



CRPS: A fact-based definition

THIS year's publication and continuing medical education program:

American Academy of Orthopaedic Surgeons

Workers' Compensation Course

Chicago, October 26-28, 2018

Google "AAOS Workers Comp"



CRPS: A fact-based definition

FACT #13: Scientific findings have indicated that most cases which involve a diagnosis of complex regional pain syndrome are associated with a compensation claim.



CRPS: most cases are associated with a compensation claim.

Greiffenstein project:

**Five research centers, three cities,
two countries,
contacting every relevant clinic –
EVERY CRPS case involved a
compensation claim.**



CRPS: most cases are associated with a compensation claim.

Verdugo and Ochoa NIH-funded project:
**81% of CRPS cases were
specifically workers
compensation claims.**



CRPS: most cases are associated with a compensation claim
**American Medical Association Guides to the Evaluation
of Disease and Injury Causation:**

**"An interesting and medically unexplainable
concern is that occupational injury (Worker's
Compensation) involves a minority of the total
number of injuries that occur, and yet in published
case series CRPS seems to be concentrated in
compensation settings."**



CRPS: A fact-based definition

FACT #9. In 2012, the International Association for the Study of Pain (IASP) changed its conceptualization of complex regional pain syndrome. One of the many changes involved the introduction of a third sub-concept, referred to as complex regional pain syndrome not otherwise specified...

FACT #9 (continued). ...complex regional pain syndrome not otherwise specified... created for clinical presentations which only partially match up to IASP diagnostic requirements for complex regional pain syndrome type one or type two...



IASP diagnostic requirements for complex regional pain syndrome type one or type two...

- 1. Continuing pain, disproportionate to any historical event.**
- 2. 3 symptoms from these 4 categories: Sensory (e.g. allodynia), vasomotor (e.g. skin temperature), sudomotor/edema (e.g. swelling), motor/trophic (e.g. tremor)**
- 3. At least one physical exam “sign” from the same four categories**
- 4. “There is no other diagnosis that better explains the signs and symptoms.”**



9 (continued). ...complex regional pain syndrome not otherwise specified... presentations which only partially match up to IASP diagnostic requirements for complex regional pain syndrome type one or type two.

Consequently, there is no longer any expectation that two clinical presentations which are both labeled with the complex regional pain syndrome concept will have anything in common

(e.g., one can involve pain in the absence of swelling or any other characteristics of the concept, another can involve only swelling in the absence of any pain or any other characteristics of the concept, etc.).

Facts of relevance to CRPS claims



**According to the modern IASP
conceptualization of complex
regional pain *syndrome*,
the concept is NOT actually a
syndrome**



9 (continued). ...complex regional pain syndrome not otherwise specified... presentations which only partially match up to IASP diagnostic requirements for complex regional pain syndrome type one or type two.

This development
drastically increased the
unreliability and ambiguity
that has plagued the concept since its
creation.



9 (continued). ...complex regional pain syndrome not otherwise specified... presentations which only partially match up to IASP diagnostic requirements for complex regional pain syndrome type one or type two.

**Every one of us,
every person on Earth,
can now be diagnosed with
complex regional pain syndrome.**



CRPS: A fact-based definition

FACT #1. Complex regional pain syndrome is an unreliable concept that was CREATED by a “special consensus conference” which was reportedly organized by two people in 1993.



**CRPS was created by a “special consensus conference”
which was reportedly organized by two people in 1993**

**It was CREATED,
rather than discovered.**

**There was no scientific discovery
which prompted
the creation of this concept.**



**CRPS was created by a “special consensus conference”
which was reportedly organized by two people in 1993**

**It was CREATED to replace
reflex sympathetic dystrophy,
which had been a
complete scientific failure.**



CRPS was created by a “special consensus conference” which was reportedly organized by two people in 1993

It was CREATED due to scientific failures, rather than due to any scientific discovery.



**CRPS was created by a “special consensus conference”
which was reportedly organized by two people in 1993**

***Bonica’s Management of Pain,
Third Edition***

***CRPS was created as an
admission of ignorance***



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1993: CRPS is created

**the creation of the construct
involved**

**“acknowledging a lack of
scientific understanding”**

(Stanton-Hicks et al, *Pain*, 1995)



CRPS: A fact-based definition

FACT #4. Complex regional pain syndrome was created in a fashion that causes it to be a pervasively non-scientific, even anti-scientific, concept.



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1993: CRPS is created

The concept was intentionally created in a fashion that was so **ambiguous** that it would be able to “**stand despite any scientific findings**”

(Stanton-Hicks et al, *Pain*, 1995)

1993: CRPS is created



able to “stand despite any scientific findings”

The creators of the concept were attempting to ensure that CRPS could never be exposed to the type of scientific scrutiny that doomed reflex sympathetic dystrophy.

Think of the Daubert falsifiability principle.



CRPS: A fact-based definition

FACT #7. Consistent with the overall effort to ensure that the complex regional pain syndrome concept would be **extremely ambiguous**, the 1993 “special consensus conference” designed the concept to be an ambiguous **“umbrella term”**, **rather than to represent a reliable concept.**



CRPS: A fact-based definition

FACT #11. The concept of complex regional pain syndrome has not been reliable from one published source of information to another, and the concept has not even been reliable over time in regard to single sources of information.



CRPS: Unreliability of the concept

- **The first publication of the concept did not match up to the intentions of the creators (so the creators responded by publishing their own conceptualization).**
- **The International Association for the Study of Pain has formalized two conceptualizations, which do not match one another.**
- **The American Medical Association has formalized three conceptualizations, which do not match one another.**
- **The AMA and IASP conceptualizations have never matched one another, and have usually been markedly discrepant.**



CRPS: A fact-based definition

FACT #20. A 2014 “comprehensive and critical review” concluded that: “There are no standards which can be applied to the diagnosis and would fulfill definitions of evidence-based medicine.”



CRPS: A fact-based definition

**FACT #10. The concept is
devoid of any
pathophysiological
considerations.**



CRPS: A fact-based definition

FACT #17. The concept of complex regional pain syndrome has not been scientifically validated as actually corresponding to any health condition.

1997: The American Medical Association's *Guides Library*

The concept of CRPS does not represent a verified discrete health condition, or even a universally recognized health condition.

2001: The American Academy of Neurology

**Biller, J (Chair), et al.
Neuropathic pain and iatrogenesis.
Iatrogenic Neurology,
Continuum
American Academy of Neurology**

**2001: The American Academy
of Neurology**

**“complex regional pain
syndrome...(is) purely descriptive,
devoid of evidential medical
power, and evasive of the
refutability principle.”**

**2001: The American Academy
of Neurology**



**CRPS is a “mythical
diagnostic term”...**

2001: The American Academy of Neurology

CRPS as a “mythical diagnostic term”

“When testable diagnostic hypotheses are ruled out, and the treating doctor does not understand the case, a mythical diagnosis is entertained. Mythical diagnoses are characterized by a wishful descriptive term and a hypothetical underlying mechanism that cannot be tested. Therefore, the hypothesis cannot be validated, but neither can it be ruled out. The “diagnosis” therefore becomes permanent and condemns a patient to chronic illness behavior and iatrogenesis.”

2008

***The American Medical
Association's Guides to the
Evaluation of Permanent
Impairment, Sixth Edition***

**2008: The American Medical Association's
Guides to the Evaluation of Permanent
Impairment, Sixth Edition**



- the concept of CRPS has not been scientifically validated as representing a specific and discrete health condition
- the diagnostic process is unreliable
- there is no gold standard diagnostic feature which reliably distinguishes CRPS claims from presentations which clearly do not involve CRPS

**2008: The American Medical Association's
Guides to the Evaluation of Permanent
Impairment, Sixth Edition**



- **empirical findings have actually indicated that whenever this diagnosis is made, it is probably incorrect**
- **all of the associated physical signs and radiologic findings of CRPS can be created through disuse**
- **an extensive differential diagnostic process is necessary**

**2008: The American Medical Association's
Guides to the Evaluation of Permanent
Impairment, Sixth Edition**



- differentials which must be ruled out before a CRPS diagnosis is made include disuse atrophy and a variety of other psychological explanations for the presentation
- the exclusion of CRPS from diagnostic consideration is necessary if any of the differentials cannot be ruled out
- such a differential diagnostic approach is necessary due to the general lack of scientific validity for the concept of CRPS, and due to scientific reports which indicate that any of the differentials would provide a far more probable explanation for the clinical presentation than CRPS would.



CRPS: A fact-based definition

FACT #16. Scientific findings have indicated that all of the objectively verifiable clinical issues that have been written into various conceptualizations of complex regional pain syndrome (e.g., swelling, trophic changes) *can be created through disuse.*

CRPS: *created through disuse*

A treatment program focused on reversing disuse reliably eliminates the physical manifestations which have been written into the concept of CRPS (specifically including edema, skin color asymmetry, temperature asymmetry, and abnormal sweating) as well as subjective complaints (e.g., allodynia) (de Jong 2005)



CRPS: A fact-based definition

FACT #15. Scientific findings have indicated that relevant clinical presentations are *often intentionally self-inflicted.*



CRPS: A fact-based definition

FACT #14. Whenever this diagnosis is made, some form of pre-existing psychopathology is usually involved in the clinical presentation.

1993: CRPS is created



**Created based on the model
for mental illnesses, rather
than based on the model for
general medical conditions**

(Stanton-Hicks et al, *Pain*, 1995)



CRPS: A fact-based definition

FACT #19. Scientific findings have indicated that the majority of people who receive such a diagnosis will demonstrate invalid clinical presentations, when scientifically validated objective testing is administered.



CRPS: A fact-based definition

FACT #21. A variety of health science publications have called for the abandonment of the complex regional pain syndrome concept...



CRPS: A fact-based definition

21 (continued). A variety of health science publications have called for the abandonment of the complex regional pain syndrome concept.

In addition to the concept's ambiguity, unreliability, and lack of scientific credibility, the reasons for such calls for abandonment of the concept include reports that the utilization of the concept deprives patients of adequate diagnosis, and consequently, deprives patients of adequate treatment.



CRPS: A fact-based definition

FACT #12. A defining (“distinguishing”) characteristic of complex regional pain syndrome causes it to be an inherently non-injury-related issue, and scientific findings have similarly highlighted its non-injury-related nature.

Facts of relevance to CRPS claims



Created in a fashion that causes it to be an inherently non-injury-related concept

- Proportionality standard of causation science
- prevention/elimination standard of causation science
- Injury have never been a requirement of any of the formal diagnostic methods



CRPS: A fact-based definition

FACT #18. Scientific findings have indicated that relevant clinical presentations have *a very favorable prognosis,* typically resolving within months.



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Facts of relevance to “Concussion”



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Brain Injury

***American College of Occupational
and Environmental Medicine, 2014***

Mayo Clinic, 2015

***American Academy of Disability
Evaluating Physicians, 2016, 2018***



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Mild Traumatic Brain Injury

(mTBI)

85% of all brain injuries

(Larrabee. Forensic Neuropsychology, 2nd Ed., 2012)

Mild Traumatic Brain Injury **(mTBI)**



**The term “mTBI” is preferable to
“concussion” because:**

- **published definitions of
“concussion” are contradictory of one
another**
- **Prominent definitions range from the
mildest of mild traumatic brain
injuries, to severe traumatic brain
injuries**

Mild Traumatic Brain Injury



Definition and Diagnostic Protocol

World Health Organization

**Based on review of
>38,000 scientific citations**

WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury Operational Definition of MTBI

- ***MTBI is an acute brain injury resulting from mechanical energy to the head from external forces***
- ***Operational criteria for clinical identification include...***



WHO Operational criteria for clinical identification include...

A. One or more of the following

- 1. Confusion or disorientation***
- 2. Loss of consciousness for 30 minutes or less***
- 3. post-traumatic amnesia for less than 24 hours***
- 4. Other transient neurological abnormalities such as focal signs, seizure, intracranial lesion not requiring surgery***

(continued)

WHO Operational criteria for clinical identification include...

B. Glasgow Coma Scale score of 13-15 after 30 minutes postinjury or later upon presentation for healthcare

C. These manifestations of MTBI must not be:

- 1. Due to drugs, alcohol, medication***
 - 2. Caused by other injuries or treatment for other injuries***
 - 3. Caused by other problems***
 - 4. Caused by penetrating craniocerebral injury***
- 

Mild Traumatic
Brain Injury



Outcome /
Prognosis

mTBI: Outcome



**All of the following
organizations have
published attempts at
comprehensively reviewing
the scientific literature...**

All of these organizations have published attempts at comprehensively reviewing the scientific literature...



**...and their reviews revealed that
there is
insufficient scientific support
for claims of permanent
impairment from a
mild traumatic brain injury
(or even persistent impairment)...**

Insufficient scientific support for claims of
permanent impairment from mild TBI...



- **World Health Organization**
- **American Academy of Clinical Neuropsychology**
- **American Medical Association**
 - **Institute of Medicine**
- **Department of Veterans Affairs / Department of Defense**
- **American Psychiatric Association**

Examples of relevant literature

World Health Organization

“Volume 1”: 1980–2000

Carroll LJ, Cassidy JD. PROGNOSIS FOR MILD TRAUMATIC BRAIN INJURY: RESULTS OF THE WHO COLLABORATING CENTRE TASK FORCE ON MILD TRAUMATIC BRAIN INJURY. J Rehabil Med 2004; Suppl. 43: 84–105.

*reviewed more than
38,000 scientific citations*

World Health Organization

reviewed more than 38,000 scientific citations

“The stronger studies, utilizing appropriate control groups and controlling for confounding factors, suggest that post-concussion symptoms are largely resolved within three months to a year.”

(continued)

World Health Organization

reviewed more than 38,000 scientific citations

“Studies that examined the relationship between *litigation and/or compensation issues and slower recovery* after mild traumatic brain injury consistently reported an association between them.”



Replication

World Health Organization

“Studies that examined the relationship between *litigation and/or compensation issues* and slower recovery after mild traumatic brain injury consistently reported an association between them.”

Kashluba S et al.

Persistent Symptoms Associated with Factors Identified by the WHO Task Force on Mild Traumatic Brain Injury.

The Clinical Neuropsychologist,

22: 195-208, 2008.

**Replication of WHO Finding Regarding Risk
Factors for Persistent Symptoms**

Kashluba S, et al., 2008.

Compared

**mTBI with persistent symptoms
to**

**mTBI without persistent
symptoms**

(continued)

*Replication of WHO Finding Regarding Risk
Factors for Persistent Symptoms*

Kashluba S, et al., 2008.

**“Compensation-seeking status and
premorbid mental health related
factors were the only variables
associated with persistent
symptom complaints.”**

(continued)

*Replication of WHO Finding Regarding Risk
Factors for Persistent Symptoms*

Kashluba S, et al., 2008.

**“Injury severity factors
did NOT differ
between the groups.”**

(continued)



**Replication of WHO Finding Regarding Risk
Factors for Persistent Symptoms**

Kashluba S, et al., 2008.

**“Studies investigating the
relationship between litigation
and/or compensation issues and
slower recovery post-MTBI
usually report an association.”
(several references listed)**

World Health Organization

“Volume 2”: 2001-2012

77,914 scientific citations considered

Linda J. Carroll, et al.

Systematic Review of the Prognosis After Mild Traumatic Brain Injury in Adults: Cognitive, Psychiatric, and Mortality Outcomes: Results of the International Collaboration on Mild Traumatic Brain Injury Prognosis. Arch Phys Med Rehabil, 2014 Mar;95(3 Suppl):S152-73.



World Health Organization

“Volume 2”: 2001-2012

Godbolt AK, et al. Systematic Review of the Risk of

Dementia and Chronic Cognitive Impairment

After Mild Traumatic Brain Injury. Arch Phys Med Rehab, 2014, 95 (3 Suppl 2), S245-56.

**“There is a lack of evidence of
an increased risk of dementia
(chronic cognitive
impairment) after MTBI.”**

World Health Organization

“Volume 2”: 2001-2012

Cancelliere C, et al. Systematic Review of

Return to Work

**After Mild Traumatic Brain Injury. Arch Phys Med Rehab,
2014, 95 (3 Suppl 2), S201-9.**

**“MTBI is not a significant
risk factor for long-term
work disability.”**



**Insufficient scientific support for claims of
permanent impairment from mild TBI...**



American Academy of Clinical Neuropsychology

**Examples of relevant
literature**

***American Academy of Clinical
Neuropsychology***

**Mild Traumatic Brain Injury And
Postconcussion Syndrome.**

Author: McCrea MA.

Oxford University Press. 2008.



American Academy of Clinical Neuropsychology
Mild Traumatic Brain Injury
And Postconcussion Syndrome.

Key points

in research subjects who are
free from known financial incentives:

symptoms,

postural stability,

and neuropsychological testing,

all normalize within 7 days,

consistent with animal experiments regarding
post-mTBI neurometabolic cascade

**Insufficient scientific support for claims of
permanent impairment from mild TBI...**



American Medical Association

Examples of relevant literature

***American Medical Association
Guides to the Evaluation of
Permanent Impairment
6th Edition (2008,2009)***

***“the symptoms of MTBI generally
resolve in days to weeks, and
leave the patient with no
impairment”***

AMA Guides 6th Edition

“the symptoms of MTBI generally resolve in days to weeks, and leave the patient with no impairment”

Passed AMA review at least two more times

Barth RJ. Determining Injury-Relatedness, Work-Relatedness, and Claim-Relatedness. AMA Guides Newsletter, May/June 2012.

Barth RJ and Meyers JE. Rating Cognitive Impairment, Part 2: Objective and Evidence-Based Integration of Neuropsychology Testing. AMA Guides Newsletter, March/April 2017.

Insufficient scientific support for claims of
permanent impairment from mild TBI...



Institute of Medicine

***Gulf War and Health:
Volume 7: Long-Term
Consequences of Traumatic
Brain Injury, 2008.***

Institute of Medicine, 2008



Reviewed over 30,000 scientific citations

**“the committee found
...inadequate and insufficient
evidence of an association
between mild TBI and
neurocognitive deficits”**

Institute of Medicine, 2008



Reviewed over 30,000 scientific citations

“the committee concluded that there was inadequate and insufficient evidence of an association between mild TBI and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently.”

Insufficient scientific support for claims of
permanent impairment from mild TBI...



**Department of Veterans Affairs
& Department of Defense**

***Clinical Practice Guideline for
Management of Concussion /
Mild Traumatic Brain Injury,
2009***

Veterans Affairs / Defense, 2009



“Concussion/mTBI is a common injury, with a *time-limited and predictable course*. The majority of patients with concussion/mTBI *do not require any specific medical treatment*”

“The *vast majority* of
patients who have
sustained a
concussion/mTBI improve
with *no lasting clinical
sequelae*”

“Patients should be reassured
and encouraged that the
condition is transient and full
recovery is expected. The term
'brain damage' should be
avoided.”

Veterans Affairs / Defense, 2009



- The *vast majority of patients recover within hours to days*, with a small proportion taking longer. In an even smaller minority, symptoms may persist beyond six months to a year
- The *symptoms associated with Postconcussion Syndrome are not unique to mTBI*. The symptoms occur frequently in day to day life among healthy individuals and are also found often in persons with other conditions such as chronic pain or depression.

Veterans Affairs / Defense, 2009



- Patients sustaining a concussion/mTBI should *return to normal activity* (work/duty/school/leisure) post-injury *as soon as possible*
- A gradual resumption of activity is recommended

Veterans Affairs / Defense, 2009



“In patients with persistent post-concussive symptoms (PPCS), which have been refractory to treatment, consideration should be given to other factors including psychiatric, psychosocial support, and compensatory/litigation.”

“Early education of patients and their families is the best available treatment for concussion/mTBI and for preventing/reducing the development of persistent symptoms”

Veterans Affairs / Defense, 2009



- **Medication** for ameliorating the neurocognitive effects attributed to concussion/mTBI **is not recommended**
- Medications for headaches, musculoskeletal pain, or depression/anxiety must be carefully prescribed to **avoid the sedating properties**, which can have an impact upon a person's attention, cognition, and motor performance

Insufficient scientific support for claims of
permanent impairment from mild TBI...



Department of Veterans Affairs & Department of Defense

CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF CONCUSSION-MILD TRAUMATIC BRAIN INJURY, 2016

Veterans Affairs / Defense, 2016



“It is important to recognize that the majority of individuals who sustain a single concussion recover within hours to days without residual deficits. Post-concussion symptoms are nonspecific (e.g., headache, nausea, dizziness, fatigue, irritability, concentration problems), which makes it very difficult to definitively attribute symptoms to the concussive injury, particularly as the time since the event lengthens.”

Veterans Affairs / Defense, 2016



“The vast majority of patients who develop symptoms after concussion will do so immediately.”

“...with patients that are initially asymptomatic and develop new symptoms 30 days or more following concussion, these symptoms are unlikely to be the result of the concussion and the work-up and management should not focus on the initial concussion.”

**Insufficient scientific support for claims of
permanent impairment from mild TBI...**



American Psychiatric Association

American Psychiatric Association



Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2013

“Except in cases of severe TBI, the typical course is that of complete or substantial improvement in associated neurocognitive, neurological, and psychiatric symptoms and signs. Neurocognitive symptoms associated with mild TBI tend to resolve within days to weeks after the injury with complete resolution typical by 3 months...”

American Psychiatric Association



Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2013

“Neurocognitive symptoms associated with mild TBI tend to resolve within days to weeks after the injury with complete resolution typical by 3 months.

Other symptoms that may potentially co-occur with the neurological symptoms (e.g., depression, irritability, fatigue, headache, photosensitivity, sleep disturbance) also tend to resolve in the weeks following mild TBI.”

Insufficient scientific support for claims of
persistent impairment from mild TBI...



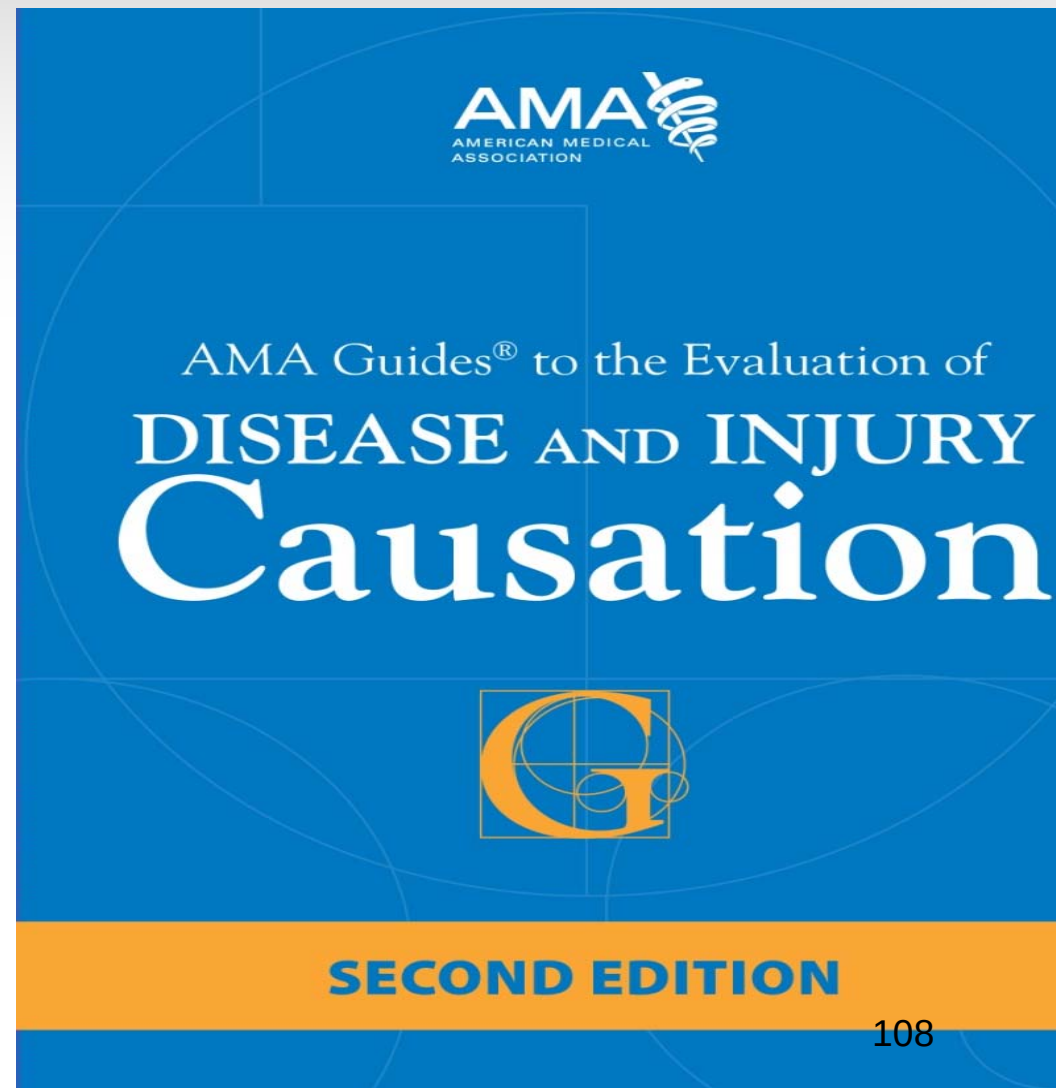
**Much more
information and
scientific referencing
is available in your
handout**



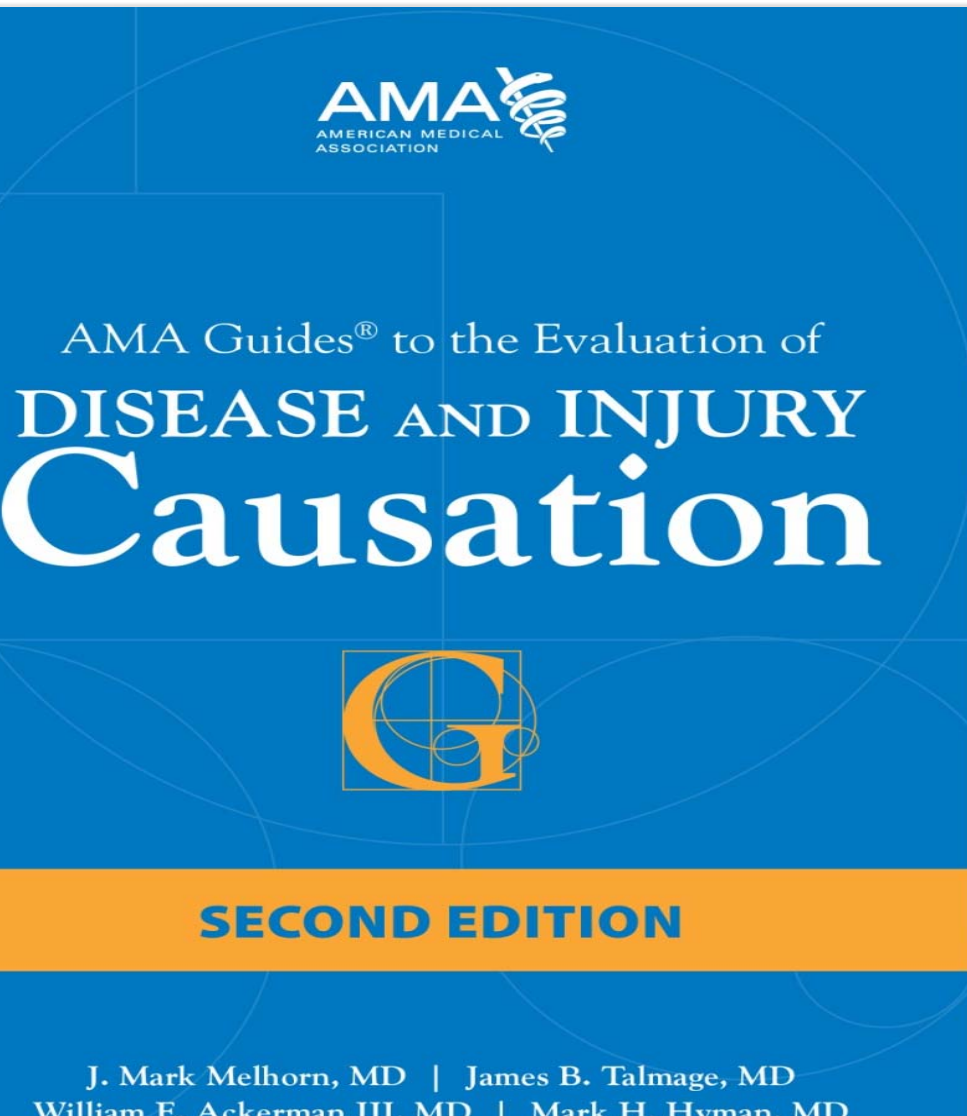
Facts of relevance to Posttraumatic Stress Disorder (PTSD)

AMA Guides to the Evaluation of Disease and Injury Causation

**This discussion of
PTSD has been
published in the
Second Edition of
the American
Medical
Association's...**



AMA Guides to the Evaluation of Disease and Injury Causation



Through two rounds of reviewing all of the scientific findings we could identify, we found zero support for the premise that civilian adult life events can cause mental illness (including PTSD).

Scientific findings have predominantly been contradictory of claims that adult life experiences cause psychopathology



- the normal human response to traumatic experiences is a phenomenon that has been labeled “posttraumatic growth”
- “positive psychological change experienced as a result of the struggle with highly challenging life circumstances”
- 75% to 90% of the survivors of traumatic experiences

Scientific Research Design

- **Group A: Everyone in the group had a traumatic experience**
- **Group B: Nobody in the group had a traumatic experience**
- **Which group has a higher rate of the syndrome that has been written into the concept of PTSD?**

Replicated Scientific Findings



- The syndrome that has been written into the concept of PTSD is actually LESS common among people who have been traumatized, and MORE common among people who have NOT been traumatized.
- Traumatic experience reliably leads to psychological improvement, rather than to mental illness.

Scientific Findings



- **For cases which involve seeking compensation, at least 73% of diagnostic claims of PTSD were attributable to seeking compensation (and could not be credibly attributed to traumatic experience).**
- **Genetics accounted for at least 34% of the variance in regard to whether someone has a PTSD-like syndrome (accounting for more variance than did trauma exposure).**

Facts regarding PTSD



The American Psychiatric Association's Guidelines for Forensic Assessment of PTSD claims

**specifies that no level of disability should
be directly or indirectly associated with a
diagnosis of PTSD.**

PTSD

- **PTSD was created in the 1980's**
- **It was created as part of a revision of the American Psychiatric Association's diagnostic system, which is commonly referred to as "DSM" (Diagnostic and Statistical Manual).**

The nature of the diagnostic system for mental disorders, as explained by the person who chaired that system for 20 years...

The Nature of the Diagnostic System for Mental Disorders



***“Mental disorders are no more
than useful constructs –***

they are not real

***and independent psychiatric
illnesses with clear boundaries.”***

The Nature of the Diagnostic System for Mental Disorders



*“There is
no scientifically proven,
single right way to diagnose any
mental disorder”.*

The Nature of the Diagnostic System for Mental Disorders



The flaws of this diagnostic system, and its vulnerability to misuse, have contributed to
“a basic background of overdiagnosis”.

The overdiagnosis phenomenon also produces
“false epidemics”, including at least four that
we are in the midst of currently.

One of the “false epidemics”: PTSD

Facts of relevance to PTSD



The manual for the DSM mental illness diagnostic system specifies that

this diagnostic system is not capable of satisfying legal/court system requirements for determining whether a disease or illness exists

in the case at hand (because of the “construct”, rather than “real”, nature of recognized mental disorders).



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Facts of Relevance to Preventing Harm from Surgery and Pain Management

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AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

*Your Source for Lifelong
Orthopaedic Learning*

19th Annual AAOS Workers' Compensation and Musculoskeletal Injuries: Improving Outcomes with Back-to-Work, Legal and Administrative Strategies

Volume 1 - Friday

*November 3-5, 2017
Las Vegas, NV*

*J Mark Melhorn, MD
Charles N. Brooks, MD
Course Directors*

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Comprehensive Treatment of Chronic Pain by Medical, Interventional, and Integrative Approaches

the AMERICAN ACADEMY of
PAIN MEDICINE
Textbook on Patient Management



 Springer

Summary:

Scientific findings have repeatedly and reliably indicated that a patient's potential for benefitting from "treatments" for chronic pain is predicted by psychological and social issues, and is NOT predicted by general medical findings.

Summary:

Method:

1. Find a doctor who is familiar with the risk factors for treatment failure
2. ***MOST IMPORTANT:*** Ask that doctor to review records from the patient's entire life, to determine if the risk factors for treatment failure are relevant to this person
 - >Patient-reported history pervasively unreliable (so we have to review records)

Summary

Method (3 and 4 can both identify risk factors that are not documented in records):

3. Psychological testing (with or without a psychological evaluation) (e.g., MMPI identified repeatedly as THE BEST predictor)

4. Psychological evaluation (TRULY independent, honest, competent)

Credible treatments for claimants?

L. Surgery that is intended to relieve back pain: For workers compensation claimants...

- More disability
- More opioids
- Elevated rate of medical complications, including death

M. Spinal cord stimulation

- For workers compensation claimants...
 - No benefit
 - More opioids
 - ○ Sentences person to a lifetime role as a patient •

Credible treatments?

N. Intrathecal pumps

- Unexplained elevated death rate
- Sentences person to a lifetime role as a patient

O. Opioid medications for chronic benign pain

- Hyperalgesia very reliable outcome
- Improvement with detox almost as reliable
- Death
- Variety of additional health problems

P. Multidisciplinary/Interdisciplinary pain programs

For workers comp, no benefit



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**Any time you save
a claimant from
any of these, the
overwhelming
probability is that
you have done the
claimant a huge
favor**

- **Surgery for pain**
- **Opioids**
- **Spinal cord stimulation**
- **Pain pumps**
- **Multidisciplinary pain programs**

**How to save chronic pain
patients from the harm that
comes from surgery,
opioids,
spinal cord stimulators,
pain pumps, etc.**

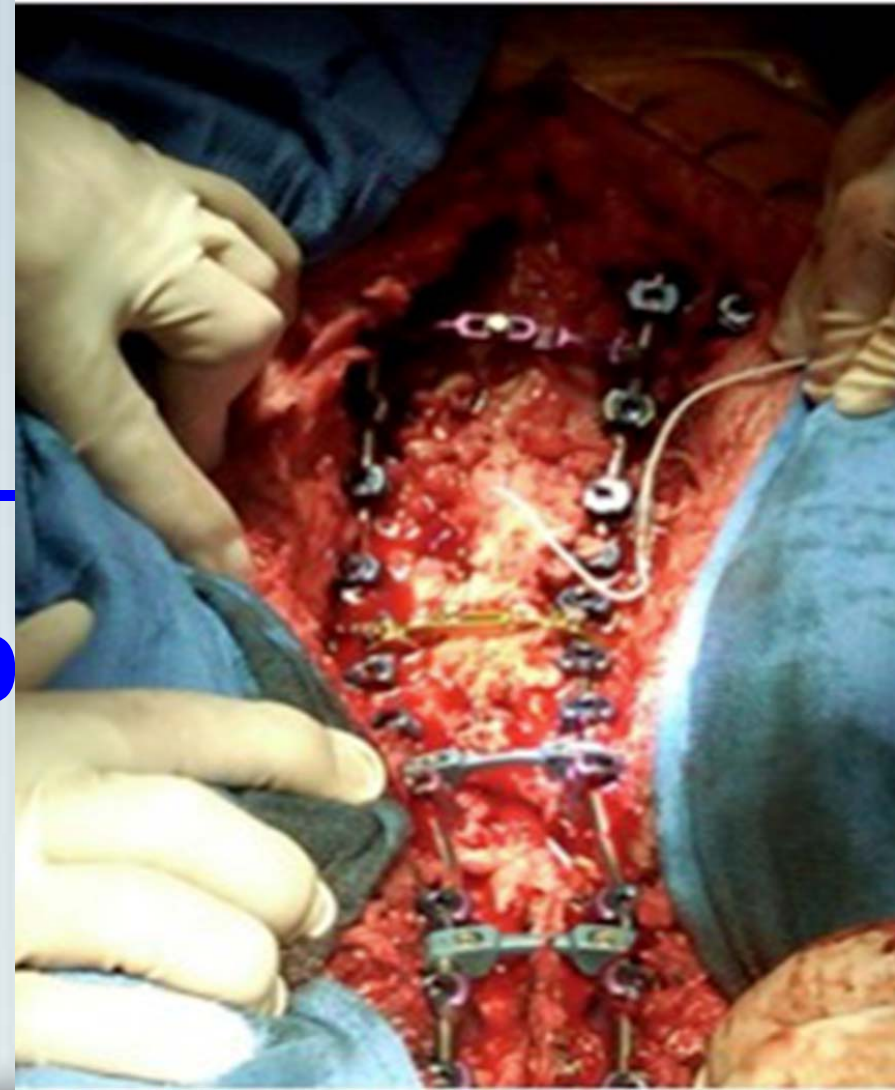
The clinicians who want to
provide these services usually
do not care about the general
science...



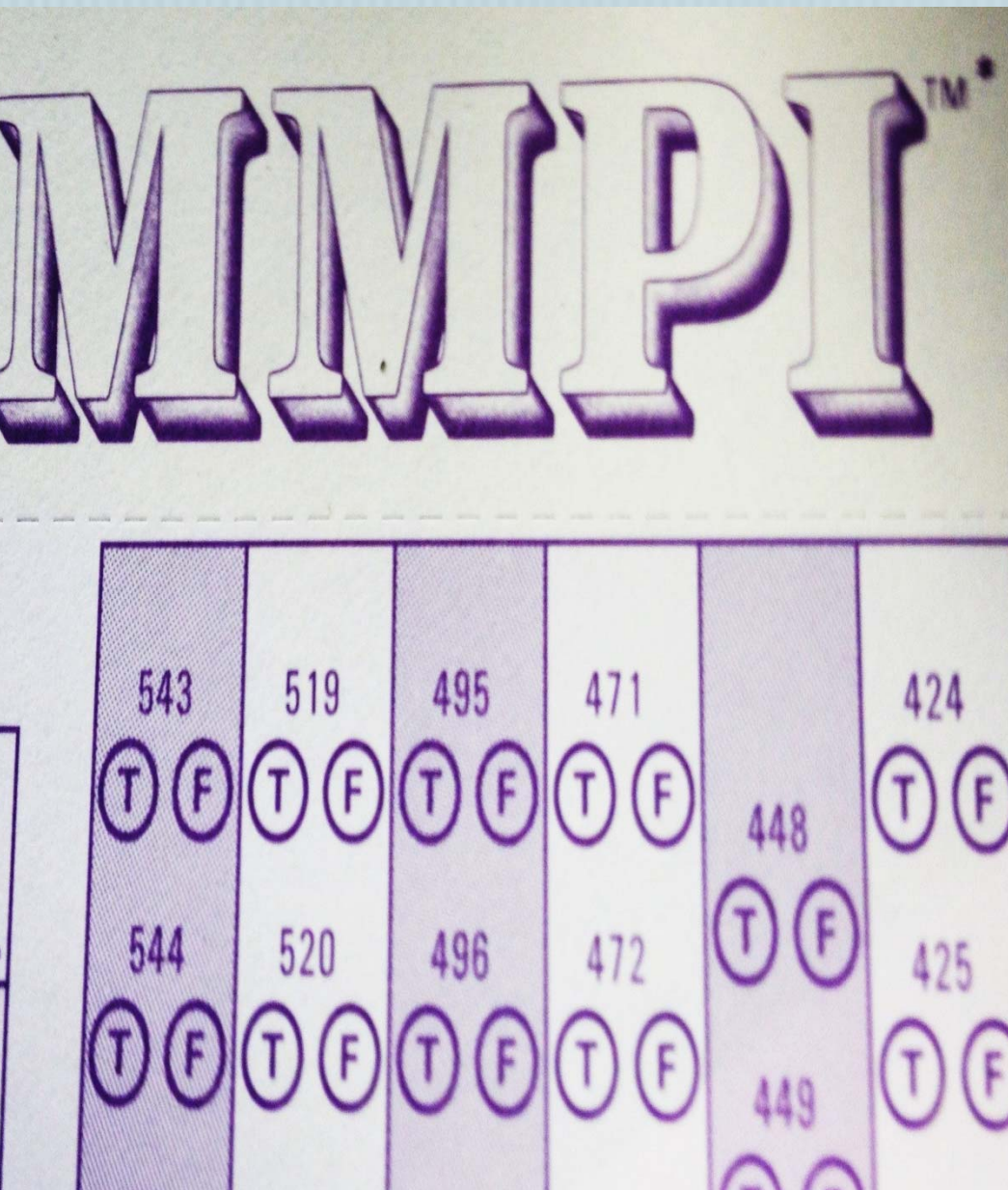
But they are more likely to pay
attention to the indications that
THIS SPECIFIC PATIENT is
likely to have a lousy outcome

True story...

The surgeon claims
that Joe *MUST*
have a spine fusion –
it is the only way to
obtain relief from
his pain.



True story...



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**The employer
arranges for Joe to
fill out two
questionnaires
(psychological tests)
at a trustworthy
local occupational
medicine clinic.**

True story...



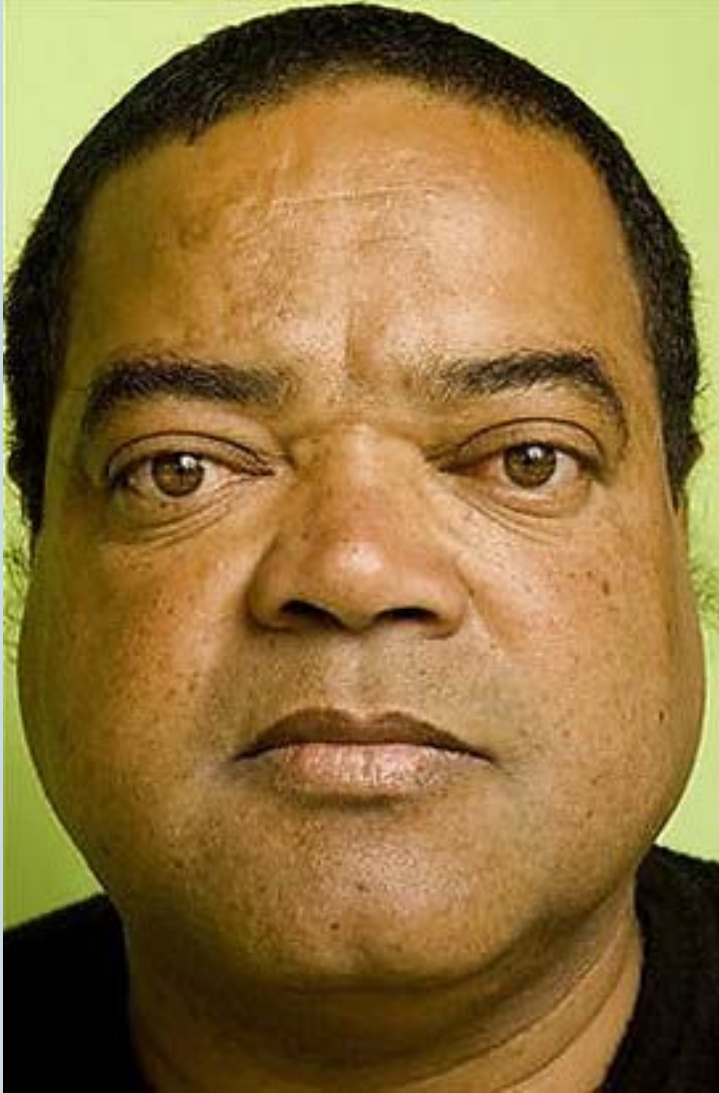
The test forms were
forwarded to me,
I analyzed the results,
and reviewed Joe's records,
then I filed a report which
explained...

My report says...

“The test data and other information from this case indicates that Joe is NOT a good candidate for the proposed spine fusion...”



My report says...



**“Objective
predictors of
a poor
outcome
include...”**

Objective predictors of a poor outcome ...

- **Elevated somatoform (psychosomatic) tendencies**
- **Elevated levels of depression**
- **Elevated levels of anxiety**
- **Consistency with a personality disorder**



Objective predictors of a poor outcome ...



- **Elevated levels of claimed disability**
- **Elevated severity of pain**
- **Elevated level of job dissatisfaction**
- **Workers compensation context**

My report says...

**“Scientific findings
have indicated
that such patients
are not likely to
benefit from spine
fusion for pain...”**



My report says...

**“...and that
such patients
are likely to file
malpractice
lawsuits.”**



The surgeon responds...



**“I would have
to be an idiot
to operate
on this patient
after reading
Dr. Barth’s report”.**



IDIOT

Educate other decision-makers

- **The claimant / family**
- **A judge / commissioners**
- **Provide:**
 - **General science**
 - **Individual contra-indications**

How do we protect patients?

When you are asked if *THIS* patient is a good candidate for surgery for pain, SCS, pumps, etc., *THESE* are the issues you should be looking at...

Alphabetized list of predictors of a poor treatment outcome:

- **Abuse/abandonment history (e.g., 85% failure rate for back surgery)**
 - **Current/recent abuse is an exclusionary factor (e.g., American Academy of Pain Medicine textbook)**
- **Activity: low level thereof**

Alphabetized list of predictors of a poor treatment outcome:

- **Age – older age**
- **Alcohol consumption (e.g., averaging two drinks per day, or more, predicts a bad outcome for carpal tunnel surgery)**
- **Anger (high=exclusionary; moderate=cautionary)**
- **Anxiety**

Alphabetized list of predictors of a poor treatment outcome:

- **Anxiety (high=exclusionary; moderate=cautionary)**
- **Attorney representation**
- **Battery for Health Improvement (BHI-2)**
 - **Any results relevant to this list**
 - **Low pain tolerance**

Alphabetized list of predictors of a poor treatment outcome:

- **Bipolar/manic-like qualities**
- **Catastrophizing**
- **Cognitive complaints/impairment**
- **Compensation (e.g., workers compensation, disability benefits, etc.)**

Alphabetized list of predictors of a poor treatment outcome:

➤ **Complaints**

- **a variety of physical complaints**

➤ **Coping inadequacies**

- e.g., catastrophizing, low perseverance, emotionality, passive/helpless attitude, considering oneself to be disabled by pain, ruminating about pain/health, frequently engaging in negative thoughts about the pain, etc.

➤ **Depression (high=exclusionary; moderate=cautionary)**

Alphabetized list of predictors of a poor treatment outcome:

- **Disability / worklessness**
 - **Being away from work for any reason**
- **Distress Risk Assessment Method (DRAM)**
 - **an elevated level of responding on this instrument, which involves two questionnaires - one addresses a wide variety of physical symptoms, e.g. dizziness, nausea, etc.; the other addresses depression**

Alphabetized list of predictors of a poor treatment outcome:

- **Doctor dissatisfaction**
- **Education**
 - e.g., having left school before graduating from high school
- **Expectations:**
 - **Unrealistic expectations of treatment success (e.g. expecting spinal cord stimulation to eliminate pain, prompt increased activity levels, facilitate return to work, etc.)**
 - **Pessimistic expectations (the patient clearly expects that the treatment will NOT facilitate a return to work)**

Alphabetized list of predictors of a poor treatment outcome:

- **Factitious characteristics**
 - e.g., a combination of relevant issues such as an extensive history of seeking healthcare, working within healthcare, worsening in response to good news from diagnostic assessments, etc.
- **Falsified information**
- **Family Dysfunction**

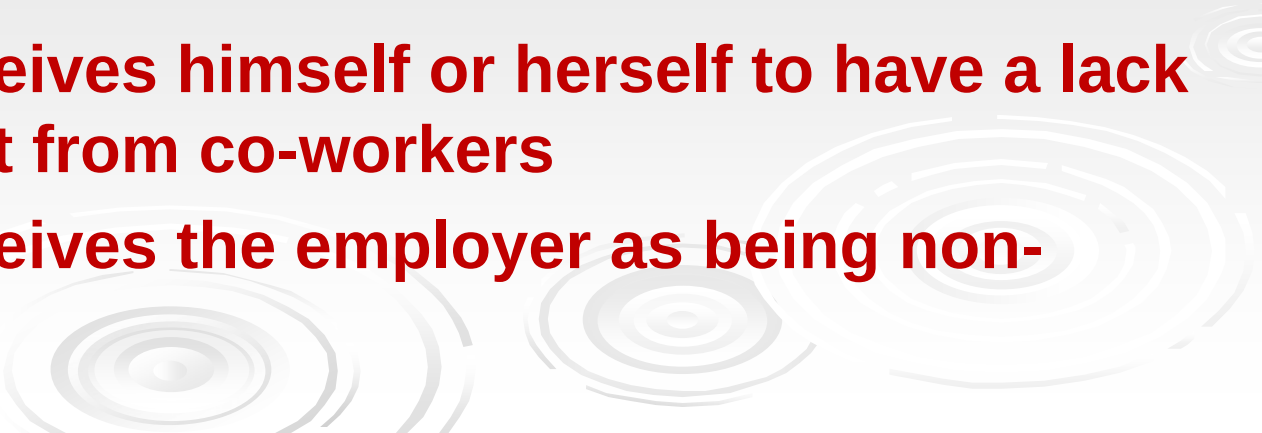
Alphabetized list of predictors of a poor treatment outcome:

- **Family history of recurrent, persistent, or severe pain; or family history of seeking healthcare for pain**
- **Homicidal thoughts**
- **Inconsistencies**
 - **e.g., physical symptoms inconsistent with pathology; inconsistencies between objective findings and/or symptom reports versus patient behavior**

Alphabetized list of predictors of a poor treatment outcome:

➤ Irritability

➤ Job considerations:

- Job dissatisfaction
 - The patient perceives the job to be psychologically demanding
 - The patient perceives himself or herself to have little control over their work and workplace circumstances
 - The patient perceives himself or herself to have a lack of job security
 - The patient perceives himself or herself to have a lack of social support from co-workers
 - The patient perceives the employer as being non-supportive
- 

Alphabetized list of predictors of a poor treatment outcome:

- **Litigation for pain and suffering**
 - e.g., Exclusionary factor according to American Academy of Pain Medicine
- **Malingering - indications thereof, e.g....**
 - Objective test results (e.g., MMPI)
 - Diagnostic considerations (e.g., noncompliance within a workers compensation context)
- **Marijuana use**

Alphabetized list of predictors of a poor treatment outcome:

➤ **Medical co-morbidities**

- **Almost any co-morbidity raises the risk of tx failure**

➤ **Medical history**

- **Almost any previous medical history is a risk factor for poor outcomes**

➤ **Mental illness (any history thereof), e.g....**

- **Formal diagnosis in history**
- **History of psychiatric medications**

Alphabetized list of predictors of a poor treatment outcome:

➤ **MMPI elevations**

- e.g., *“the most consistent relationship with reduced spine surgery results.”* (American Psychological Association review)
- Scale 1 (Hypochondriasis) elevation
- Scale 3 (Hysteria) elevation
- Elevations of relevance to depression
- Indications of impulsivity
- Consistency with schizophrenia
- Other elevations
- The “Disability Profile”; A set of results which involves elevations on any four (or more) of the traditional primary clinical scales

Alphabetized list of predictors of a poor treatment outcome:

- **Modified Somatic Perception Questionnaire (MSPQ)**
 - an elevated level of responding on this questionnaire which addresses a wide variety of physical symptoms, e.g. dizziness, nausea, etc.
 - **NOTE:** This questionnaire might be hidden, within the records, under the broader title “Distress Risk Assessment Method (DRAM)”
 - Also scientifically validated for assessing the validity of a chronic pain complaint

Alphabetized list of predictors of a poor
treatment outcome:

- **Noncompliance with health care / evaluation**
 - **“Non-organic signs”**
 - **Obesity**
 - **Opioid pain medication (any history thereof)**
- 

Alphabetized list of predictors of a poor treatment outcome:

➤ Pain issues:

- Severe pain
- A variety of pain complaints
- Pain severity that does not vary
- Long duration of pain (e.g. two years)

➤ Passive attitude

➤ Personality Dysfunction

- NOTE: Will be found for majority of patients who seek healthcare for pain, even before the pain becomes chronic

Alphabetized list of predictors of a poor
treatment outcome:

- **Psychosis –**
 - **Delusions / Hallucinations**
- **Smoking**
- **Social Isolation**
- **Somatization**
- **Spouse solicitousness, or
spouse lack of support**

Alphabetized list of predictors of a poor treatment outcome:

➤ **Stress**

- **patient has recently experienced a high level of stressful events**
- **patient reports feeling stressed**

➤ **Substance Abuse**

- **active, or in the past, including any misuse of prescription medication, and any violation of an opioid agreement**

Alphabetized list of predictors of a poor
treatment outcome:

- **Suicidal thinking**
- **Surgery history**
 - **Almost any previous history of surgery increases the risk of tx failure**
- **Symptoms that seem to be medically impossible**

Alphabetized list of predictors of a poor
treatment outcome:

- **Treatment failure**
 - Failure to benefit from previous treatments for pain is predictive of a failure to benefit from proposed treatment
- **Workers compensation**

The results of this process can also provide an objective basis for the creation of a credible treatment plan that will actually provide hope of benefit.

Review



- **Opinion-based testimony from experts is extensively corrupting and complicating legal claims, and consequently compromising the justice system.**
- **The focus on opinions is unnecessary and unjustified.**
- **The corrupting influence of opinions can be combatted through a focus on FACTS**