+Vestibular Ear Functions and the MMPI-2 FBS Tscore

----- Original Message -----

From: George Rossie

To: Neuropsychology

Sent: 05 January, 2008 10:42

Subject: RE: [npsych] Skepticism regarding other professional's opinions

> Paul, I don't think the issue is that other providers "knowingly falsify medical records", or "misrepresent" anything when they say what they say and do what they do. It is more often a matter of not taking or not having the time to thoroughly examine and thoroughly document the patient's condition. I would have no problems swearing in an affidavit that I saw someone falsifying records if I had seen that. I also have no problems documenting the results of my own examination, even if it shows PTA three days after a mild TBI, and no one else had noted it. I think my detailed examination notes and reports speak for themselves, and have often been used by attorneys for both sides in establishing early case histories. As far as what do I do about it when I see an inadequately documented mental status exam or findings that are inconsistent with my own? Easy, I document my findings as thoroughly as I can. And what would I do if I saw someone one year later with an FBS of 31? Easy...I'd look to see if anyone had examined vestibular functions, since in my experience **(a) high FBS is the single best predictor of inner ear disturbance.**
>
> George Rossie

To: npsych@neurolist.com Subject: Re: [npsych] Skepticism regarding other professionals opinions From: pkaufmann2@unlnotes.unl.edu Date: Sat, 5 Jan 2008 09:21:40 -0600

In many of these cases, orientation to time and/or place was actually not assessed and all the cranial nerves were not assessed, particularly the olfactory nerve, which is a problem considering that olfaction can be impaired after orbitofrontal injuries. I know of no such study so in the end we are all making assumptions about whether this is a rare or common occurrence. I can only speak from personal experience and what others I know have told me as well.

Dominic, George, Bob, John, Jason, and any others,

Fair enough, all points well taken. If I may, who among you is prepared to sign a sworn affidavit stating, "I directly witnessed Nurse A, Resident B, or Doctor C knowingly falsify medical records, misrepresenting the neurological

findings in their examination, thereby misleading this court to believe the plaintiff was neurologically intact?"

Next, who among you is prepared to add to your affidavit, "My acute bedside examination revealed that the plaintiff was not oriented to time and remained in post traumatic amnesia for three more days following mild TBI? “

Who is prepared to testify to these facts in open court and submit to cross examination?

The first question from the opposing counsel would be, "Doctor, can you show me in the medical chart where you documented the results from your examination of this patient?"

In these cases in which you directly observed misrepresentation of neurological findings, what did you do about it? I reiterate, courts presume medical records are reasonably accurate, unless and until such time specific evidence is brought forward to challenge the facts contained therein. So if you are ready to bring forward that evidence, the court will hear it and recognize that facts are in dispute. That is why we have trials. Assumptions and list serve musings about whether chart errors are rare or common do not matter if nobody presents testimony to the court. Courts presume medical records are reasonably accurate, absent evidence to the contrary.

How many of you are prepared to take issue with 12 vs. 72 hours of PTA based on inadequate medical chart data, for a patient who is complaining of PCS at one year post mild TBI, who presents with the following neuropsychological test data at one year post injury:

MMPI-2 FBS = 31, MMPI-2 RBS = 15, WAIS-III Reliable Digits = 6, WMT failure.

Stated alternatively, should we spend time arguing about assumptions we may or may not be making about one year old medical records about time orientation when we were not in the room or should we just interpret the data from a current neuropsychological evaluation? I know what the court would say.

Finally, what does our best science say about the predicting long term neuropsychological outcome based on 12 vs. 72 hours of PTA following a mild TBI?

Paul Kaufmann