

JCAHO Issues Alert

Problem of Anesthesia Awareness

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued an alert on Oct. 6 cautioning health care providers about the dangers of "anesthesia awareness." The organization asserts that tens of thousands of patients undergoing surgery each year remain partially awake while under general anesthesia during surgery, but are unable to communicate this problem to their caregivers. JCAHO's alert aims to make health care providers more aware of this phenomenon so that they can reduce the risks of its occurrence and better support patients when it does happen.

The problem of anesthesia awareness affects an estimated 20,000 to 40,000 patients each year, with cardiac, obstetric and major trauma patients being at higher risk, according to the JCAHO. "Anesthesia awareness is under-recognized and under-treated in health care organizations," says Dennis S. O'Leary, MD, president, Joint Commission. "The Joint Commission understands that anesthesia professionals must balance the psychological risks of anesthesia awareness against the physiological risks of excessive anesthesia. This alert is intended to help health care organizations address this problem in an open and constructive fashion."

WHAT THE ALERT SAYS

The alert advises the development and implementation of an
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Mild Traumatic Brain Injuries Pose Different Set of Rules

By Gerald Tramontano, PhD

Part One of a Two-Part Article

Patients in hospitals and nursing homes sometimes get injured, perhaps when they become disoriented and try to get out of bed unassisted or are being moved by hospital staff from a gurney to a bed. Patients can experience cerebral hypoxia (*ie*, a deficient oxygen supply to the brain) from anesthesia or surgical complications.

Medical malpractice lawsuits often follow, with plaintiffs asserting that the hospital, nursing home staff or physicians failed to properly monitor and maintain the patient's safety. These plaintiffs may claim to have suffered acquired brain injuries (ABIs) or traumatic brain injuries (TBIs) that continue to hinder their ability to function in their everyday lives. However, while these assertions may be true, they call for further investigation on the part of the defense. Plaintiffs in medical malpractice actions have a financial incentive for exaggerating their symptoms, so an evaluation should be made to determine if the plaintiff is malingering.

As with any personal injury case, in a case involving an ABI or TBI, the plaintiff must demonstrate that the client was affected in terms of limitations and disabilities. However, the difference between an ABI or TBI case and many others is that in a case involving brain injury, the attorney must be able to *prove the injury itself*. Rather than physically showing before-and-after evidence — as one would in an accident involving broken bones or paralysis — the injury must be shown to have limited the plaintiff's ability to function cognitively, emotionally, socially and/or vocationally. A fair number of mild brain injury individuals may even appear to have normal cognitive functions and will be shown to have retained their cognitive abilities on neuropsychological testing, yet, when placed in interpersonal situations, will exhibit symptoms that have adversely affected their lives.

TRAUMATIC BRAIN INJURY: ITS CONSEQUENCES

A relatively common but often misdiagnosed condition where cognition can be relatively intact — though the patient is no longer able to function at the pre-morbid level

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Brain Injuries

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— is Organic Personality Syndrome. This syndrome often results from damage to the orbitofrontal lobes. Personality functioning (*ie* temperament and personal characteristics) has changed. Often, the condition will present in two different ways in the same individual. If the surrounding environment is relatively tranquil or limited in stimulation, the patient may show little motivation or activity, suffering from what is clinically known as dysbulia, which is almost always mistaken for depression. On the other hand, if the environment is perceived as over-stimulating, the result may be emotional and behavioral dysregulation. Additionally, these individuals often present with social pragnosia, a condition under which they no longer make the appropriate social judgments they could easily make before their injuries occurred.

There are many instances of lives ruined by this syndrome. I have seen it deprive a grandfather of the right to visit with his grandchildren, due to his son's concern over his inappropriate and even lewd remarks when the children were present. It destroyed a corporate executive's ability to handle the stress and multitasking required of his position, costing him his career. It changed the dynamics in a young woman's marital relationship because of increased anxiety and mood swings, forcing the breakup of her marriage. In all three cases, these individuals were cognitively intact, but limited in their ability to deal with the demands of their lives.

Much of this emotional deregulation does not necessarily present itself overnight following the injury that precipitates it. It happens once a

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patient becomes integrated back into each layer of his or her life. During the weeks following the injury, a mild TBI victim typically takes it easy, recovering from the symptoms common of a concussion. Once the individual starts to feel better and is once again confronted by the full spectrum of problems and other stimuli that life has to deliver, he or she becomes more symptomatic. Secondary and tertiary psychological reactions to these brain changes tend to make the condition worse, particularly in patients with brain injury who have a prior psychiatric history. The victim of an ABI or TBI, noting that the changes in his or her condition following the injury are not disappearing, may become more anxious and depressed.

DIAGNOSIS

A neuropsychological workup is the only standard test for evaluating cortical functions. While a psychological test or psychiatric exam will diagnose psychiatric disorders like post-traumatic stress disorder and schizophrenia, it will not discern neurocognitive and neurobehavioral syndromes such as dysbulia, dysexecutive syndromes or apraxia. Since psychiatric disorders — like major depression — can also affect brain functions, a psychiatric exam is built into every neuropsychological evaluation. When it comes to patients with injuries to the orbital frontal structure, the assessment itself may include a range of exams from a smell identification test (the olfactory bulb sits right in the middle of the orbital front cortex), to tests of cortical inhibition, to family members being asked to rate the individual on personality and emotional/social functions before and after the injury on standardized neurobehavioral measures.

This kind of testing is not only a valuable tool for the attorney who needs to show, quantify and document evidence of brain pathology, but it can demonstrate normal brain functioning. It can also help identify those individuals who are malingering or embellishing their cognitive and psychiatric symptoms.

MALINGERING

The motivation for litigants to perform poorly on cognitive and psychological tests can be extremely

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Brain Injuries

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powerful due to the potential for earning lucrative rewards. Some plaintiffs can be quite sophisticated and cunning in their attempts to avoid detection. In addition, experts in clinical neuropsychology must be able to separate true malingerers from those suffering from a psychiatric illness or an acquired or traumatic brain injury that may result in a cognitive, behavioral and/or emotional disorder as a result of the underlying neurological damage or illness.

Unlike genetic or blood chemistry testing, there is no biological marker that can conclusively determine whether a patient is volitionally exhibiting signs of malingering. As a result, it is incumbent on the expert — usually a clinical neuropsychologist — to make a determination based on various criteria, just as he or she would with any other behavioral, psychiatric or neuropsychiatric diagnosis, like depression or visual hallucinations.

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but failed to warn her that the drug could cause even more life-altering headaches. She asserted that she'd lost work because of the debilitating headaches brought on by the drug's use. The defense countered that she'd had these medical problems before she began using Botox and that, even after she claimed to have been incapacitated by the effects of the drug, she continued to attend Hollywood parties. The jury's verdict is the first reported decision in a case involving Botox.

MARYLAND DOCTORS

TRY NEW GAMBIT

Finding that their physician rally during the last legislative session had little or no impact on legislators who could push for tort reform in their state, Maryland's doctors plan this fall to enlist the help of their patients. They will be leaving pre-printed postcards in their offices for patients to pick up and mail to their legisla-

Correctly diagnosing malingering begins with a definition of the condition. According to *The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition*, published by the American Psychiatric Association, malingering is “the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs.”

While the lack of a biological marker makes it less than an exact science, experts must look at discrepancies between the patient's medical history and clinical presentation, as well as between behavioral observations conducted with the patient and information acquired from family members during the clinical interviews and neuropsychological test results. In addition, recent technological advancements in neuropsychological testing and improvements in defining criteria for malingering of cognitive and psychiatric disorders have added

important tools to the expert's arsenal in diagnosing malingerers.

A significant portion of diagnostic research of the cognitive and psychiatric malingered patient has been devoted to using traditional neuropsychological tests to not only examine brain functioning, but also to use these same test results to diagnose malingering. This is done via a “pattern analysis” of the test results. The remaining portion of research in this area has been devoted to the development of better tests and improved normative data to reduce the false positives and negatives in diagnosing malingering. These “malingering” tests within the context of a comprehensive neuropsychological exam have substantially improved the clinical neuropsychologist's ability to correctly diagnosis a patient's cognitive or neuropsychiatric disorder.

In next month's newsletter, we'll look at the methods experts are now using to detect malingering in TBI plaintiffs.



tors, saying “I am worried, and I vote.” The goal is to get the word out to legislators that not only are medical care providers concerned with rising malpractice insurance rates, their numerous voting patients are also worried that their health care options might be affected by insurance issues.

DOCTORS LOOK FOR DONATIONS

The Washington Post reported in September that some physicians are asking their patients to voluntarily contribute money toward their rising malpractice insurance premiums. (Boodman, *The Washington Post*, 9/21/04). Although this may come in the form of a surcharge, many doctors who ask for payments that will pay their insurance costs characterize them as donations, not as a fee, because Medicare prohibits such charges. This latest tactic in the fight to stay afloat under the crushing weight of malpractice insurance premiums may backfire if patients, who may earn far less than their physicians, see these requests as over-

reaching on the part of what is often considered an overpaid profession.

FLORIDA VOTERS TO DECIDE MED-MAL QUESTIONS

At press time, Florida's voters were considering three malpractice-related proposals to change the state's constitution. One proposed amendment calls for physicians to lose their licenses after receiving three unfavorable judgments in malpractice lawsuits. Their licenses would not be pulled, however, if the lawsuits ended in settlement. A second proposed amendment would allow patients to look at the safety records of their physicians. The third constitutional amendment on the ballot would limit the percentage of malpractice awards attorneys could receive as compensation.



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