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Subjective Complaints v. Objective Signs

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THE WORD "VERSUS" in the title[1] presents what we think is one of the most important problems of plaintiff trial lawyers today. After years of preparation, we submit our case to a jury; our medical witnesses offer testimony based on long time observation, treatment and evaluation. Then, in walks the defendant's doctor and proceeds to plunge a dagger into our case by calling our client either a malingerer or a neurotic, or just a plain liar. He testifies that he saw none of the objective signs that our medical examiners found, and concludes that all of the subjective complaints are imaginary or faked. Call it by any other name, it is murder in the courtroom. Your case may expire under the knife of this witness, right then and there.

We quote from the transcript of a case we recently tried in federal court. This was a rear-end collision case where we had proved a herniated disk by three doctors: the general practitioner, an orthopod, and a neurosurgeon, all highly qualified. There had been no surgery prior to trial, because the client feared the operation. This is the testimony from defendant's neurosurgeon, a diplomate and a recognized, competent neurosurgeon, based on a thirty minute medical examination:

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[1] Definitions from: Blakiston's New Gould Medical Dictionary (2d ed., 1956).

Complaint: Lay term for disease or ailment.

Presenting Complaints: The symptoms of which the patient is aware and which brings him to the physician.

Subjective: (1) Pertaining to the individual himself; (2) Referring to symptoms experienced by the patient himself, and not amenable to physical exploration.

Objective: (1) Pertaining to an object or to that which is contemplated or perceived, as distinguished from that which contemplates or perceives; (2) Pertaining to those relations and conditions of the body perceived by another, as objective signs of disease.

Sign: A mark or objective evidence; in a restricted sense, a physical manifestation of disease.

Symptom: A phenomenon of disease which leads to complaints on the part of the patient; a subjective sign in contrast to one which is objective.

"Q. You say he is a liar?

A. Some of the findings made me feel that; yes, sir.

Q. You say now he is a liar, that he suffered no injury from this accident?

A. No, I did not say he suffered no injury, sir.

Q. What injury did he suffer?

A. I think he may have had a mild ligamentous strain of his neck and back.

Q. How do you know if it's mild or slight or severe?

A. On the findings, the occurrence of changes in the reflexes.

Q. Then you did find some evidence of mild strain of the ligaments?

A. No, I did not find anything.

Q. How do you draw the conclusion, then, that at least he had mild strained ligaments?

A. On the basis of the history.

Q. You feel he had some injury?

A. He may have; yes, sir.

Q. Definitely, you say it has all healed up, is that correct—nothing wrong with him, in your opinion?

A. In my opinion, I do not feel there is.

* * * * *

Q. Then, Dr. Smith, are you saying that this man is a liar?

A. Well, I had to come to this conclusion."

This testimony hopelessly divided the jury, and, since we were in federal court requiring unanimous verdict, a mistrial was declared.

Dr. Smith called our client a liar. Everything about our case refuted this charge. We began to search for a personality defect in the doctor. We cross-examined him on an article by Dr. Thomas S. Szasz, a Professor of Psychiatry, entitled "What is Malingering?" [2] We challenged the doctor on the ground that his name calling was not a scientific diagnosis, but a moral judgment, which he had no right to make. Dr. Smith disagreed with the following statement by Dr. Szasz:

Malingering is not a diagnosis in the usual sense of the word. It expresses the physician's or psychiatrist's moral

[2] Szasz, What is Malingering? Med. Tr. T. Q. 271 (1960).

condemnation of the patient, in general, and of a specific pattern of behavior in particular. It tells us more about the observer, the physician, or psychiatrist, than it does about the observed, the patient.

This line of examination may have convinced some, but not all of the jurors that something was wrong with the witness.

Subsequently, the plaintiff in the federal trial was operated on by his neurosurgeon, and a herniated disk was discovered. The interesting fact is that the operation was performed exactly one day before Dr. Smith took the stand to testify against us in a second trial involving a different client. The second trial concerned the case of a painter who fell from a ladder some eight feet, broke his left os calcis, and sustained head injuries. About a year after sustaining this injury and before trial he became dizzy while painting, and fell again, sustaining a fractured skull. By the time Dr. Smith examined him for the insurance company on the subject of the first accident, he had already had this second accident. Dr. Smith took the position that there was no longer any sign of brain injury (despite two head injuries), and that the painter was suffering from a "traumatic neurosis" which he said was the same as a "compensation neurosis"; and said further that the painter would recover as soon as he had a money verdict in his pocket. Shortly after the painter's trial, we received a call from a lawyer in our community who would also be faced with Dr. Smith in a brain injury case. We furnished our transcripts to him. He cross-examined Dr. Smith, and developed that in a period of fifteen years, the neurosurgeon had testified in about 75 cases, and that in 1/3 of these cases, he testified that the symptoms of brain injury would disappear as soon as there was a money verdict for the injured party. Because most cases have lately been successful in discrediting this doctor's testimony by the cooperation of plaintiffs' counsel in exchanging transcripts, we felt that a review of some of his statements with a psychiatric interpretation might add new techniques to trial effectiveness.

Here are some excerpts from the trial of the painter:

"Q. By the way, is a traumatic neurosis an unusual thing after an injury?

A. Some people call them compensation neurosis.

Q. Is that the same thing, doctor?

A. Precisely the same.

Q. That means you are looking for compensation, is that it?

A. Yes, that's right."

The terms "compensation neurosis" and traumatic neurosis are not synonymous terms. Physicians should not utilize the expression "compensation neurosis" in that it occupies no official, recognizable position as a diagnostic entity. As a matter of fact, if one is to utilize the concepts of Dr. Szasz it is here that one might say that the doctor is making a moral judgment. In other words, the term "compensation neurosis" has an unfavorable connotation; it is a dirty word implying an admixture of lying or malingering and/or unconscious exaggeration of symptoms in order to obtain something positive for the patient involved. For purposes of medical testimony it is not an accurate expression, and should be attacked by the cross-examiner with psychiatric text in hand.

Also, doctors should try not to use the expression "traumatic neurosis." If an individual has developed a certain clinical neurosis following a trauma, he should be diagnosed as having that particular neurosis, in the official terminology of the medical profession.[3] The expression, "traumatic neurosis," like "compensation neurosis," occupies no official status. By fairly common medical practice "traumatic neurosis" is utilized to describe certain relatively uncommon situations found primarily in military settings. The doctors instead should use a diagnostic category such as "conversion reaction" or "anxiety reaction," or "psychophysiologic reaction" of a certain type. Actually even the traumatic neurosis in the military sense usually fits into the category of "acute anxiety reaction." Communication would be enhanced if doctors, attorneys and other people used the same terms in the same way. "Compensation neurosis" because of its varied usage is a relatively meaningless term.

We pushed the doctor all the way on his diagnosis.

"Q. And you are saying in every traumatic neurosis, as soon as the man gets whatever he is looking for he is going to get better; is that correct?

[3] Diagnostic and Statistical Manual—Mental Disorders, American Psychiatric Association, 32, 1952. "In recording such reactions the terms 'traumatic neurosis' or 'traumatic reaction' will not be used; instead, the particular psychiatric reaction will be specified."

A. Yes, that is essentially so. It is accepted psychiatric principle that a psychiatrist will not treat anyone with a compensation neurosis when litigation is pending. After it is settled, that is a different question.

Q. Let me ask you this: If Mr. Jones has a traumatic neurosis—assume that he does have, for a minute. If this case is concluded and he gets every single penny he asks for, will he get well the next day, the next week, or the next month? When is it going to happen?

A. He is always going to have trouble with his left ankle.

Q. There is no neurosis about that?

A. No, sir.

Q. He is only neurotic above the waist, is that correct? Below the waist he is not neurotic?

A. You are just a neurotic from your mind, from your nose up, if you would like to be specific.

Q. Just a neurotic from the nose up. I see.

A. Yes.

Q. Assume Mr. Jones has a traumatic neurosis—and you say that is just because he unconsciously wants compensation—how soon can we look to see him completely well if he gets everything he wants in this lawsuit?

A. I think he will feel very much better as soon as he gets a check in his pocket.

Q. He is going to be completely well then, as soon as he gets the check?

A. What symptoms?

Q. About his headaches and all the symptoms.

A. He may have headaches from different causes.

Q. But this condition is going to go away on that day, you can count on that?

A. That is medical opinion, yes, sir.

Q. It won't even take a week, it will be just that day, the first day?

A. That's right."

This neurosurgeon thus takes an extremely dogmatic approach in his "psychiatric" testimony.

Firstly, it has been traditionally accepted in medical textbooks, that the so-called "compensation" or "litigation neurosis" disappeared upon the conclusion of the litigation. While this

particular subject has not been adequately scientifically explored (attorneys might keep this in mind as a future research project), the current trend of opinion among psychiatrists is that these situations very often are continuing and disabling after settlement, an opinion based on impression, rather than on adequate scientific knowledge. A difficulty that arises, which is quite pertinent here and which might be considered in cross-examination of the neurosurgeon, is the lack of follow-up study on such patients. On what grounds can a neurosurgeon make the statement that such symptoms dissappear? He may see the patient claimant once or twice for purposes of evaluation, in order to provide expert testimony. Rarely does he have the opportunity to further examine or treat such patients. Certainly, persons he examines for insurance companies will not be returning for further treatment to defendant's medical expert. On what grounds, then, can a defendant neurosurgeon state that from his own experience such symptoms disappear? His experience might well be too limited.

Since the witness was a neurosurgeon, we must raise the question as to the degree of his competency about conditions that he states are psychiatric. Neurosurgery does not confer any special qualification as to psychiatric matters. The neurosurgeon generally has little or no formalized education and training in things psychiatric.[4] Because this is also true of other medical men, we find in the testimony of various medical specialists an extreme degree of semantic confusion, and perhaps vague or erroneous "psychiatric" testimony. The trial lawyer must be familiar with psychiatry, so that he can expose the inadequacies of the neurosurgeon and other physicians who are really in dangerous territory when they make psychiatric value judgments.

It is the duty of the local trial bar to expose the bias and inadequacy of the medical witness who becomes a danger in the courtroom. Dr. Smith was invited by the trial bar to give a talk on his favorite courtroom diagnosis: "traumatic neurosis." This was transcribed and used in the courtroom to good advantage. There is nothing unfair about this procedure (and a copy should immediately be handed to the witness if he says "I haven't seen a copy of that talk"). Doctors should be willing

[4] Tuchler, The Traumatic Neurosis: A Perspective, 1 J. For. Sci. (1) 65-80. (1956).

to live by their statements. The ultimate search is for truth in law and medicine, whether we speak in the lecture hall or in the courtroom.

Counsel may wish to attack the testimony of the defendant's medical expert by having that expert testify as to the non-neurotic elements of the claimant; every facet of the claimant's behavior is used to discredit the witness, as follows:

"Q. Now, as distinguished between a neurosis and a real injury, there are certain factors we can look at in the individual's personality, are there?

A. Yes, there are.

Q. Certain people would be more prone to a neurosis than other people?

A. Yes, that is true.

Q. And if a man works, and returns to work promptly after the cast is removed as fast as he can, that tends to indicate he has a real injury rather than a neurosis, wouldn't it?

A. Yes, that would indicate a stable personality.

Q. And if a man had a service connected disability and made no claim for any compensation from the United States Government, that would tend to show, would it not, that he was not a neurotic type of personality?

A. Yes, it certainly would.

Q. And if a man will work whenever called to work, at every opportunity, despite pending litigation, that would tend to show that there is a man who does not have a neurotic tendency, wouldn't that be a fact?

A. Yes, sir, I would agree with that.

Q. And if a man signs out of a hospital after a serious injury, against the advice of his doctor, that he wants to go home, that is a thing that tends to show he is not neurotic, doesn't it?

A. No, I would disagree on that.

Q. You think that shows that he is neurotic?

A. I would question some of his judgment.

Q. You would question some of his judgment?

A. Yes. If signing out—if he had a severe injury of any sort, signing out, against medical advice—

Q. That wouldn't show he is a very clever person medically, but does that show that he is neurotic? Doesn't that have a tendency to show away from neuroticism?

A. That would not indicate either way. I wouldn't want to say.

Q. You wouldn't draw any conclusion?

A. No, sir.

Q. Do you remember if he said, 'If you give me back my leg again you can keep everything else'? Do you remember him saying that?

A. Yes. I have that in the notes.

Q. Does that tend to show a neurotic personality?

A. No, it does not, not that alone."

Counsel has here indicated that if the doctor has testified on a moral, non-scientific basis, he has made a shaky diagnosis. As a "post-traumatic neurosis" ordinarily assumes the pre-existence of a neurotic personality, (although some writers disagree) the testimony has further probative value in demonstrating that the claimant did not have a severe "neurotic predisposition."

Counsel, having proved that the doctor is a poor evaluator of our client's personality, now wishes to get the doctor to separate "neurosis" from "malingering" by using Brock's text; but failing that, counsel wants the doctor to agree that plaintiff's symptoms could come from an organic post-concussion syndrome, without "neurosis" or "malingering" entering the picture at all, and the following testimony developed:

"Q. Do you know of Brock's book 'Injuries of the Brain and Spinal Cord and Their Coverings'?

A. Yes.

Q. Do you not consider that book an authoritative work in the field?

A. Yes. People who write books have so many opinions. That is why there are so many different books.

Q. Do you agree with this opinion, 'Riese (1929) and Schnyder (1936) emphasize that even after lump sum settlement, difficulties of neurotic character often remain.' You wouldn't agree with that, would you, doctor?

A. No, I do not. That is contrary to my experience.

Q. You say this traumatic neurosis is just a form of greed of one form or another, subconsciously?

A. Yes. That is the opinion of many people.

Q. Would you say this opinion is in error, by the same author, 'Attempts are made to separate compensation neu-

rosis from traumatic neurosis, in the narrower sense. However, if one considers that human beings live in a social environment, one must be very careful before deciding that neurotic symptoms are merely due to greed and an unwillingness to work'? Do you think that is wrong?

A. I disagree with it.

Q. You disagree with it?

A. Yes, sir.

Q. What is a post-concussional syndrome, doctor?

A. A post-concussional syndrome is a group of symptoms that follow a head injury. It may be composed of intermittent headaches. The patients may have some personality change by irritability, they may have attacks of dizziness. I think those are most important.

Q. That is not a neurosis, is it?

A. No, sir, that is not.

Q. Would you say it is fair to say that sometimes these symptoms can persist for very long periods of times without any neurosis, whether you call it shell shock or anything else?

A. The post-concussional?

Q. Yes.

A. Yes, sir, they may.

Q. For years?

A. Yes, sir, they may."

Now with a transcript of the federal trial in hand, the one in which the jury disagreed, counsel moves in to show that this is a biased witness:

"Q. Have you found in your experience, doctor, that you have been called upon rather frequently by counsel for defendants to examine and testify?

A. Yes, I have.

Q. As a matter of fact, principally, as far as your involvement in medical legal matters, you have been called upon by defendants; isn't that a fact?

A. Yes. More defendants than plaintiffs.

Q. Yes. And, doctor, you have found that you have expressed this same view that people are neurotics or malingerers in some instances in a great number of cases; isn't that right?

A. Yes, sir, I have.

Q. And you have testified to that effect in this Court House, Federal Court House, all over the place; isn't that right?

A. I have testified here; and I have, in Federal Court, once in my life.

Q. When were you in Federal Court?

A. You will have to ask Mr. Sindell. He was there. Or his brother.

Q. Oh, yes. That was the John Tubbs case, wasn't it?

A. I believe so.

Q. You said he was a liar; isn't that right? You used that word?

A. I don't have the records here.

Q. I have it.

A. Fine.

Q. Would you like to look at a transcript from the Federal Court Reporter?

A. May I read this to get an accurate idea?

Q. Surely.

A. 'By Mr. Sindell:

'Q. Dr. Smith, are you saying that this man is a liar?

'A. Well, I had to come to this conclusion.'

* * * * *

(See first page of this article).

* * * * *

A. I didn't quite come out and call him a liar. I think I had some other basis. This man again said he couldn't bend over to put on his shoes, and yet, when you watched him—

Q. He was a malingerer and a liar then?

A. Well, I think you have to draw that conclusion in certain cases.

Q. Would you be interested in knowing, doctor, that on Tuesday John Tubbs entered the hospital and the herniated disc you said did not exist was excised by Dr. Green, at Memorial Hospital?

Mr. Brown: I object. He is giving a speech and not asking a question.

The Court: Is that the plaintiff involved in the Federal case?

Mr. Brown: That's right, your Honor.

The Court: You only asked him if he was familiar. He can answer yes or no.

Q. Do you know John Tubbs was taken to Memorial Hospital on Tuesday, they opened up his back and looked, and they found the herniated disc and took it out? Do you know that?

A. I did not know that.

Q. Doctor, you said at that time that he didn't have anything wrong with him at all, did you?

A. I did not feel that he did; no, sir."

This cross-examination accomplished two purposes. The credibility of the witness has been attacked by indicating a bias or prejudice, in that the doctor is indicated to have personally testified in a similar manner previously. The jury senses that either he committed a grave injustice to the litigant by his moral and rather cruel judgment, or that he made a grievous error in diagnosis—and by inference could be mistaken more than once. This is an extremely interesting subject, since testimony, even by professional experts, is highly determined by unconscious factors and attitudes within the witness, although it is obviously impossible to conduct a psychiatric study of the witness in the court room.[5] However, the attorney, by his line of questioning, has brought to the attention of the jury the drive within the witness to attack the credibility of subjective complaints of persons claiming personal injury. The lawyer may not be able to bring out the psychological basis, but sometimes by the artful creation of extremely stressful questions, the defenses of the doctor are shattered to the extent that the doctor reveals more openly his own personality rather than the impartial objective attitude supposedly typical of the scientific witness.

Dr. Durval Marcondes in his article, "New Aspects of the Clinical Interview: Countertransference Difficulties" [6] points out how the personal factors within the physician interfere with such objectivity. He says:

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[5] Record of Transcript in: Curran, Law and Medicine, 577-582, (1960).

[6] 22 Psychosomatic Medicine (3) 211-217 (1960).

"A correct behaviour toward the patient demands that the doctor be able to take sufficiently into account his own countertransference reactions. If, as is perfectly permissible, we wish to apply to the doctor in general what Racker says concerning the psychoanalyst, we may say that the doctor's objectivity consists above all in a certain attitude towards his own subjectivity and countertransference. Instead of blocking subjectivity, true objectivity of the doctor consists, as the same author points out, in becoming the object of one's own continuous observation and analysis, which will permit one to become truly 'objective' toward the patient."

There is here as in most witnesses an unconscious determinant in the personality of this doctor which hampers him in objectively evaluating the patient's subjective complaints. He rejects them and so he cannot properly evaluate them; his own problems have blocked his true understanding. Whether this can be shown in the courtroom is highly problematical.

Some lawyers think it helpful to indicate that the witness is so interested in fees that he cannot or will not listen to the patient. We tried the "fee" approach:

"Q. How much do you charge Mr. Brown for examining this man?

A. I charge $50 for an examination and report.

Q. And how many cases have you examined for defendants within the last six months?

A. I would say on the average of perhaps three times a week, three or four a week.

Q. In six months that is 4 times 25, that is 100 times $50, that is $5,000; is that right.

A. In the last six months?

Q. Yes.

A. If that is what it adds up to, yes, sir.

Q. And you say *Mr. Tubbs* has a compensation neurosis; is that right?

A. No, *I did not say that.*

Q. That is all, Doctor." (emphasis added).

Although trial lawyers feel that the revelation of compensation to the doctor is not of great significance, and these questions are generally avoided, some might feel that the income of $5,000.00 in the six months period for medical examinations

and reports might have some impact on the jury. We doubt whether this line of questions is effective in creating the impression that the doctor is testifying for monetary purposes. However, it does make the point that there is something highly desirable about this witness from the standpoint of defense attorneys and would add to the implications of bias already made. Also, the introduction of monetary matters is often extremely upsetting to the doctor witness, and under the stress of the moment the doctor witness often makes ill advised remarks from the standpoint of his employer, and that is exactly what occurred here. Plaintiff's attorney by going from the subject of compensation to "compensation neurosis" obtained an admission from the witness that the claimant had no compensation neurosis, and in essence the doctor has reversed himself, and negated his previous testimony in which he said that the plaintiff had a "compensation neurosis."

After the painter's case was tried to a successful conclusion, we received a telephone call from another trial lawyer who was faced with the same doctor, and he obtained a copy of the record of testimony from which we have been reading. This attorney had also checked out another lawsuit in which the same neurosurgeon had made a diagnosis of malingering, and now he had three previous cases with which to cross-examine the doctor.

We will see how he gets Dr. Smith to admit that he has diagnosed "malingerer" in more than the previous three cases—that he has done it in approximately twenty-five cases out of seventy-five.

> "Q. I see. And now, Doctor, your testimony here, and the report as you have submitted to Mr. Brown with reference to the fact that a patient will recover upon the conclusion of a lawsuit, that, basically, is a portion of your testimony; is it not?
>
> A. Yes, sir.
>
> Q. That statement has been consistent with the testimony that you have given and you did give, for example, in this Tubbs case that Mr. Brown represented the defendant in?
>
> A. Yes, sir.
>
> Q. All right. You remember testifying in the case where Mr. Grimm represented the plaintiff and Mr. O'Brien

represented the defendant before Judge Allen and that the testimony as you have given here today is substantially along the same lines with reference to the fact that the conclusion of the litigation will conclude the damage; is that true?

A. Yes, sir.

Q. And how many other cases do you recall that you testified in, in behalf of the defendant that your testimony was along the same line?

A. About 75 times in five years.

Q. Well, what percentage of those cases that you have testified in have you come to the same conclusion as you did in this case that the money judgment would cure the patient?

A. Well, let's say one-third of the cases I testified in, that is a guess.

Q. Well, Doctor, for those that you have most recently testified, that would be the one you testified for Mr. Brown, the one you are testifying for here today, and the one you testified to before Judge Allen, these are the most rcent cases you have testified in behalf of the defendants, is that so?

A. On behalf of the defendants, yes, sir.

Q. All three of them, your testimony has been the same way with respect to the fact that the litigation would probably conclude the patient's complaints?

A. Yes, sir."

We have here presented a case study of what we consider to be a biased medical witness, and methods used to discredit such a witness.

This neurosurgeon has made it more difficult for himself to be accepted as an impartial witness in the future. By tending to tag people as malingerers he has indicated both a tendency to make judgments as to the morals of the plaintiff, and a reflection of his own bias. If he had merely indicated that there were "unconscious distortions," his testimony might be readily acceptable and understood by jurors. But, by his own selection of words which undoubtedly express his own inherent feelings, he has now cast some doubt, with the aid of an opposing attorney, on his objectivity, and can be attacked in this way in subsequent lawsuits in which he is called upon to testify.

In cases where the medical witness goes beyond listening to subjective complaints and looking for objective signs and makes a judgment in psychiatric terms, the lawyer representing the plaintiff is duty bound to inquire into the psychiatric training of the medical expert particularly if his diagnosis is verbalized in the nomenclature of psychiatry. Here we have a neurosurgeon who has made a diagnosis based on a neurological examination and who has produced a series of labels—"traumatic neurosis" (which he equates with "compensation neurosis") and "malingering" (or "lying"). What is there about this doctor which alerts the psychiatrist? What has this neurosurgeon projected out of his own personality? Is there something different in the make-up of a neurosurgeon from an obstetrician, let's say, or a general practitioner which leads him to make such evaluations?

The attorney must constantly be alert to the fact that many physicians depending upon their personalities and specialties cannot tolerate uncertainty or indecision. Therefore, patients, without demonstrable objective signs to justify the complaints presented, are labeled as "neurotics" or with the other terms mentioned above as if by the very fact of such labeling the situation has been solved. In essence the use of such terms by many doctors is merely an admission that the physician is unable at that given moment to make a definitive medical diagnosis. Perhaps we need more doctors who will restrict their opinions to such statements of lack of confirmation without proceeding further.

An interesting article[7] which illustrates the almost universal presence of unconsciously determined "bias" reported that even ultrascientific workers such as pharmacologists tended to be consistent in making certain kinds of drug evaluations, the judgments being determined strongly by the unconscious attitudes of the pharmacologist.

Another point raised is the question of specific psychodynamic factors operating in the neurosurgeon himself, a question applicable to all medical witnesses. There have been attempts made to study the personality types of doctors in the different fields of medicine; for instance, Karl Menninger has written a series of articles on "Psychological Factors in the

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[7] Greiner, Subjective Bias of the Clinical Pharamacologist, 181 J. Amer. Med. Asso. (2) 120-121 (1962).

Choice of Medicine as a Profession" and in the choice of specialties.[8] It has been stated that surgeons sometimes choose their field because of alleged unconscious sadistic tendencies. Even if one subscribes to this belief, it does not mean that surgeons are sick people. Some surgeons may have paranoid tendencies which are allowed a very socially acceptable expression; mild traits of paranoia or grandiosity are sometimes compatible with a good adjustment through one's choice of profession. While not scientifically demonstrated, there is a general impression that neurosurgeons represent the epitome of such character types. The need to be above and better than other people, the need to be certain, the need to solve problems in a dogmatic but remote manner are all encompassed in this concept. The doctor and especially the surgeon occupies a magical position in all societies. He is independent; he is a financial success; he solves problems quickly through his own judgment; and he feels answerable to no one except to God. Few people in this complex world that we live in have such an opportunity for successful utilization of a paranoid and grandiose type of personality. Such good fortune, however, is balanced by certain burdens. Not being able to depend or rely upon others, such a person must make quick and certain decisions as dictated by the nature of his work. Complicating this is the fact that doctors like other people are not only individuals but they are also human beings and so all of the psycho-dynamic factors present within an individual become expressed in his professional functions. That explains why in the field of psychiatry, stress is put upon the introspective evaluation of the psychiatrist himself because, only by understanding himself, can one be truly objective in understanding others. This type of semi-philosophic attitude is alien to the training of most doctors. However, it does partially explain the liberality, if not looseness of thought, so frequently characteristic of psychiatrists. We think that in a closed head injury case, we will more frequently find a neurosurgeon testifying for a defendant, while a psychiatrist testifies for a plaintiff. This is no mere accident of fate but represents a bias of the specialties as well as the biases inherent in the individuals involved.

We conclude by saying that the biased medical witness can be exposed by:

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[8] Menninger, Psychological Factors in the Choice of Medicine as a Profession, 21 Bull. Menninger Clinic, 51-58, 99-106 (1957).

1. Pooling of resources of the local trial bar.

2. Use of transcripts in other cases where the witness made similar charges of malingering or neurosis without adequate psychiatric foundation.

3. Showing the inadequate psychiatric training and experience of the witness.

4. An understanding of the personality of the witness.

5. A thorough grounding in the use of psychiatric terms, and the various psychiatric categories and entities.

6. Complete preparation of the facts of the client's pre-accident personality, and his reactions to the injury which indicate that he is not a neurotic personality.

7. An understanding of organic bases for syndromes following head injury.

8. A familiarity with the medical literature, so as to make the cross-examination in all areas effective.

By all of these methods, we may be able to save our case from murder in the courtroom.