

Pulling a fast one?

Linda Monaci & Flora Wood examine the approach to applying malingering diagnostic criteria in cases involving head injury

IN BRIEF

► Methods used to identify malingering neurocognitive dysfunction to assist lawyers in deciding if there are grounds to plead fundamental dishonesty in the discrete area of brain injury.

The introduction of the concept of “fundamental dishonesty” to the defendant’s armoury in personal injury cases raises the stakes for litigants. If exposed, a claimant risks having their QOCS protection taken away or their entire claim struck out if the trial judge finds that they have been fundamentally dishonest in relation to “any aspect of the claim”. This article explores some of the methods used to identify malingering neurocognitive dysfunction (MND) to assist lawyers in deciding whether, perhaps, there are grounds to go as far as to plead fundamental dishonesty in the discrete area of brain injury.

Case law

The case law on the application and definition of fundamental dishonesty is still at a fledgling stage but was neatly summed up by Freedman J when considering CPR 44.16 in the case of *Zurich Insurance v Bain* (unreported, 4 June 2015): “What does fundamentally dishonest mean? It does not, in my judgment, cover situations where there is simply exaggeration or embellishment... Having said that, these cases are fact sensitive and there may be situations where if a claim is patently and obviously exaggerated, the sole purpose being to recover damages to which a claimant is not entitled, it may be that a judge concludes that that renders the claim fundamentally dishonest.

“Where I am quite satisfied fundamental dishonesty does arise is where it goes to the core of the claim. If the dishonesty is really at the root of the claim then it seems to me that the dishonesty can properly be categorised as being fundamental.”

Can neuropsychological assessment assist in establishing not just a simple exaggeration of the limits of cognitive function, but one which “patently and obviously” exaggerates the seriousness of the impact of the brain injury “so that it goes to the core of the claim?” An example might be a claim for significant

past and future care costs (claimed as a result of an alleged inability to live independently due to short term memory or concentration problems) which is clearly discredited by medical experts.

Malingering

Malingering is a common human behaviour; it is the fabrication of symptoms with the purpose of obtaining secondary gains, such as financial compensation or avoiding duties such as school or military service.

Judges require clear unequivocal evidence to find fraud or dishonesty. Are we any nearer acknowledging an accepted criterion for malingering which will enable independent medical experts to conclude there is a significant probability that the claimant is malingering?

Assessing for symptom validity

Internationally it has been agreed that assessing for symptom validity, including effort, is nearly always necessary. There are also guidelines to help identify malingering in acquired brain injury and in chronic pain (eg Bianchini et al., 2005; Slick et al., 1999). Research has mainly focused on validating assessment tools and the main conceptual framework has considered malingering for the purpose of financial gain (eg Boone & Lu, 2003; Green, 2001; Heilbronner et al., 2009; Iverson & Binder, 2000).

It is important to ensure that the information collected during the neuropsychological assessment is valid. Furthermore, any indication that the data obtained is not valid (failed effort tests and/or significant elevation on symptom validity scales that suggest over-reporting and feigning) must be identified, as being either outright dissimulation or merely symptom magnification, which may not be intentional.

Several methods are offered in current literature to assess symptom validity (eg Bush et al., 2005; Reynolds 1998; Slick et al., 1999). Larrabee (2012) recently suggested the following terms should be used: performance validity (indicating effort) and symptom validity (referring to the validity of symptom report). Effort can be assessed with specific stand alone tests of effort (or embedded ones, but these are less sensitive). Self-report questionnaires can employ strategies, including monitoring

the presence of symptom magnification, reporting of unlikely, too specific or absurd symptoms, unusual symptom combinations or positive symptom distortion. Administering independent tests of effort and other measures of symptom validity, such as questionnaires, increases the validity of assessment results (Bianchini et al., 2001) and provides non-redundant information regarding the examinee’s credibility (Mittenberg et al., 2002). Consistency of information is also important; for instance the information obtained during the interview, test results, observation, self-reported history and symptoms, documented history, third party accounts and known brain functioning.

Theory for diagnostic criteria

The DSM-IV (APA, 2000) considers malingering as a behaviour, not a mental disorder per se, therefore formal diagnostic criteria are lacking. The DSM-IV defines malingering as “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” (APA, 1994, p. 683). The DSV-V (APA, 2013) considers malingering under “non-adherence to medical treatment”. Its definition is very similar to the DSM-IV, but although criteria are provided, malingering should be strongly suspected “if any combination of the following is noted: (i) Medico-legal context of presentation; (ii) Marked discrepancy between the individual’s claimed stress or disability and the objective findings and observations; (iii) Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen; or (iv) The presence of antisocial personality disorder.”

Greiffenstein et al. (1994) proposed the following criteria for the diagnosis of “overt” malingering of memory dysfunction (in particular to be used in neuropsychological settings, for claimants presenting with post-concussive symptoms): (i) improbably poor performance on two or more neuropsychological measures; (ii) total disability in a major social role; (iii) contradiction between collateral sources and symptom history; and (v) remote memory loss.

Two studies (Greiffenstein et al., 1994; Greiffenstein, Gola, & Baker, 1995) demonstrated a significant link between classifications made according to these criteria and scores on tests of effort. This supports the notion that consistency between symptoms, test performance and behaviour (both during and after the assessment) are essential to help clarifying whether malingering is present.

However, others (Pankratz & Erickson, 1990) believe that the diagnosis of malingering should be made based on behavioural observations and that understanding whether the behaviour is intentional is irrelevant. They proposed the following criteria for malingering: (i) marked inconsistency between reported and observed symptoms; (ii) marked inconsistency between diagnosis and neuropsychological findings; (iii) resistance, avoidance, or bizarre responses on standardised tests; (iv) failure on specific measures of faking; (v) functional findings on medical examination; and (vi) late onset of cognitive complaints following accident.

Others, such as Faust and Ackley (1998), however highlight the importance of volition and of providing false information (or withholding information) to make a determination of malingering. Iverson (1995) found that strategies used when attempting dissimulation included “poor cooperation, aggravation and frustration, slow response latencies and frequent hesitations, and general confusion during the testing process.”

It is important to consider the entire clinical picture as while certain type of brain dysfunction and/or premorbid personality traits may make these behaviours more likely, these could also be consistent with malingering.

Slick et al (1999) proposed a relatively comprehensive system to guide the determination of malingering in the form of categories of possible, probable, and definite malingering of neurocognitive dysfunction (MND) for the purpose of material gains (eg financial compensation) or avoiding formal duty or responsibility (eg stand trial).

Diagnostic categories for MND

Definite MND

This is indicated by the presence of clear and compelling evidence of voluntary exaggeration or fabrication of cognitive dysfunction and the absence of plausible alternative explanations. The specific diagnostic criteria necessary for Definite MND are listed below:

- i. Presence of a substantial external incentive.
- ii. Definite negative response bias (ie definite or probable negative response bias, discrepancy between test data and known patterns of brain functioning, discrepancy between test data and observed behaviour, reliable collateral reports, or documented background history).
- iii. Behaviours meeting necessary criteria from (ii) that are not fully accounted for by psychiatric, neurological, or developmental factors.

Probable MND

This is indicated by the presence of evidence strongly suggesting voluntary exaggeration or fabrication of cognitive dysfunction and the absence of plausible alternative explanations. The specific diagnostic criteria necessary for probable MND are listed below:

- i. Presence of a substantial external incentive.
- ii. Two or more types of evidence from neuropsychological testing, excluding definite negative response bias (probable response bias, discrepancy between test data and known patterns of brain functioning, discrepancy between test data and observed behaviour, discrepancy between test data and reliable collateral reports, discrepancy between test data and documented background history) or one type of evidence from neuropsychological testing, excluding definite negative response bias, and one or more types of evidence from self-report (ie self-reported history is discrepant with documented history, self-reported symptoms are discrepant with known patterns of brain functioning, self-reported symptoms are discrepant with behavioural observations, self-reported symptoms are discrepant with information obtained from collateral informants, evidence of exaggerated or fabricated psychological dysfunction).
- iii. Behaviours meeting necessary criteria for neuropsychological testing and self-report are not fully accounted for by psychiatric, neurological, or developmental factors

Possible MND

This is indicated by the presence of evidence suggesting volitional exaggeration or fabrication of cognitive dysfunction and the absence of plausible alternative explanations. Alternatively, possible MND is indicated by the presence of criteria necessary for definite or probable MND except that other primary aetiologies cannot be ruled out. The specific diagnostic criteria for possible MND are listed below:

- i. Presence of a substantial external incentive
- ii. Evidence from self-report (ie self-reported history is discrepant with documented history, self-reported symptoms are discrepant with known patterns of brain functioning, self-reported symptoms are discrepant with behavioural observations, self-reported symptoms are discrepant with information obtained from collateral informants, evidence of exaggerated or fabricated psychological dysfunction).
- iii. Behaviours meeting necessary criteria

from (ii) are not fully accounted for by psychiatric, neurological, or developmental factors or criteria for definite or probable MND are met except for primary psychiatric, neurological, or developmental aetiologies cannot be ruled out. In such cases, the alternate aetiologies that cannot be ruled out should be specified.

Arguably, only the first two categories are likely to support an allegation of fundamental dishonesty.

The Slick criteria do not appear to be extensively used in the UK and perhaps the determination of malingering is seen as a finding of fact and as such outside the remit of a medico-legal expert. However, given the importance of ensuring no part of a personal injury claim is exaggerated, it appears even more important that clinical neuropsychologists always consider the validity of the data obtained during a medico-legal evaluation.

In the vast majority of cases there will most likely be insufficient evidence to claim an exception to the QOCS rule or dismiss an entire claim under s 57, Compensators should apply a sensible level of caution in raising these issues, unless they are prepared to accept the significant costs consequences if they fail.

Insurers and compensators will be keen to use fundamental dishonesty as a weapon against fraud. The recent case of *Hughes, Kindon and Jones v KGM* (unreported, 1 April 2016) at Taunton County Court (which resulted in a costs order against the claimants after their claims were dismissed for exaggerating the length of their recovery period) could be the start of a significant new battle to challenge a claimant's honesty. Claimant solicitors are naturally concerned for their genuine clients and defendants must be able to justify their allegations or face costs penalties and bad publicity. Expert evidence will inevitably be a key factor and the Slick categories could provide a useful framework to assist judges in considering the merits of an allegation of malingering in brain injury cases.

It should not be forgotten that the obvious route to “success” for a defendant where malingering is strongly suspected (and supported by medical opinion) is to make a well timed and carefully calculated Pt 36 offer. In cases worth less than £25,000 defendants will not get indemnity costs, even if their offer is not beaten, but in the higher value cases a win on costs can be more significant than the final compensation award.

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