

Evaluation of Dizziness in the Litigating Patient

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KEYWORDS

- Vertigo • Dizziness • Lawsuit • Litigation • Disability
- Worker's compensation • Malingering • Exaggeration

R.G. is a 50-year-old man describing nonspecific dizziness. He states that the dizziness is constant and does not come in spells. He indicates that his symptoms wax and wane in severity with no consistent pattern for time of day or inciting activity. He reports associated symptoms of headache and neck pain, which are also constant, and bilateral tinnitus. He denies hearing loss. He states that his past medical history is negative, and his physical examination is unremarkable. Toward the end of the appointment, he indicates that all his symptoms began after a motor vehicle crash and that his lawyer specifically referred him to you for evaluation, because ...you are the best doctor in town.

DIZZINESS IN LITIGATING PATIENTS

Dizziness is one of the most frequent chief complaints that brings patients to their physician's office.¹ Dizziness is also a frequent complaint among litigants who have suffered accidental or job-related injuries. Worker's compensation, disability claims, and lawsuits are filed for financial compensation because of this complaint. As physicians, we inevitably will become embroiled as either expert witnesses in our patients' lawsuits or as experts sought out by entities being sued by individuals for the alleged injury related to the complaint of dizziness. A competent evaluation of this entity is frequently sought from otolaryngologists in the position as an expert witness. This review puts forth some guidelines in dealing with this type of patient and the legal system. Although this article is entitled "Evaluation of Dizziness in the Litigating Patient," the principles set forth in it are applicable for patients who are seeking disability status, worker's compensation claims, and any other situations in which there is significant potential for secondary gain.

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BASIC PRINCIPLES***Physician Role: Patient Advocate Vs Advocate/Agent of Court***

As physicians we find ourselves in the role of patient advocate for several different causes and are taught that this is our role as physicians. We advocate for their best interests in relieving their suffering and preventing further harm to their health. We advocate for them to get insurance approval for appropriate health care, and we advocate for their disability application when appropriate. These roles are all ethical and, indeed, laudable positions to find ourselves. However, when we are in the role of expert witness, we are no longer in the role of a patient advocate. When we take on the position of a medical expert, we are, in essence, enjoined as agents of the court, and our role is to provide truthful and objective assessments of an individual's physical condition.² To advocate for the patient in this situation would be unethical. This fact is important to keep in mind because the patient's best interests may not be aligned with the best interests of the court and society as a whole.

Extensive Documentation of History and Physical Examination

Extensive documentation of the history and physical examination is an important first step in the evaluation of those who are involved in litigation. Experience has taught the authors to use an extensive pre-visit questionnaire to document the patient's responses in their own handwriting. This questionnaire is filled out in our office waiting room, signed by the patient, dated, and witnessed by one of our staff members. This questionnaire is important to document because so many of our medical opinions and diagnoses are based on information garnered from the history. This procedure may seem elaborate, but there will be times when the patient will later deny statements made in the office. Without documentation to the contrary, the expert will either be forced to change his opinion based on this "new" historical information or will be caught in a "my word against his word" confrontation. Of course, if the above-mentioned documentation occurs, any future changes in the medical history are problematic for the patient and will denigrate his reliability. Any historical information provided by the patient (or the attorney) must be corroborated by medical records, physical findings, test results, and so forth. Memory is often swayed by potential million-dollar settlements. At the same time our intake questionnaire is completed, we have the patient sign a consent form for evaluation and testing, which includes consent for photograph or video documentation. If this is not signed, we do not see the patient.

Extensive Objective Testing to Verify Complaints

Do not be cost-conscious. In this day of escalating health care costs, many physicians have been made ever so aware of ordering unnecessary testing. However, in the context of litigation, the concern of being cost-conscious is misplaced. A complete and thorough evaluation including history, physical examination, audiological testing, vestibular testing, imaging, and any other ancillary tests needed is unlikely to exceed \$10,000. Any (non-nuisance) litigation concerning dizziness almost certainly seeks redress exceeding several hundred thousand dollars and frequently exceeds a million dollars. Consequently, the costs of the evaluation by the medical expert in these cases are almost always negligible. If an attorney is reticent to proceed with a full evaluation because of the costs, this is a good clue that he does not have a case and is looking to settle for a nuisance fee.

Corroboration of Objective and Subjective Findings

Because litigation involving the complaint of dizziness often involves the possibility of very large monetary awards, there is considerable incentive for plaintiffs to malingering or to exaggerate their symptoms. Lawyers, judges, and juries are also aware of these factors, sometimes more so than physicians. Consequently, it is imperative that any subjective complaint be verified objectively and quantified as best as possible. This process will often either bolster the plaintiff's case or destroy the case entirely. However, sometimes the result is a mixture of these outcomes, helping some aspects of the case while harming the others. To the expert witness, whatever the result, it should not matter.

Make Sure All Pieces Fit: Do Symptoms and Severity Correlate with Objective Findings?

Among dizzy patients who are undergoing litigation, approximately 25% will have symptoms that are corroborated by objective testing and 25% will have nonphysiologic test results, with no objective findings to corroborate their subjective complaints (**Fig. 1**). These 2 groups would seem to be fairly straightforward—one group that seems to be fairly honest and legitimate and the other group that is highly suspicious for malingering. However, there is another larger group of patients representing approximately 50% of litigating patients complaining of dizziness who have characteristics of both—some verification of subjective findings by objective testing and some nonphysiologic results suggesting malingering or exaggeration. Putting all 3 groups together, one could reasonably say that 75% of all patients complaining of dizziness and involved in litigation are either malingering or exaggerating their problems. Or, one could also reasonably state that 75% of these patients have a legitimate pathologic condition. Both statements would be correct. Separating the true pathologic condition from exaggeration is the main role of the expert witness.³

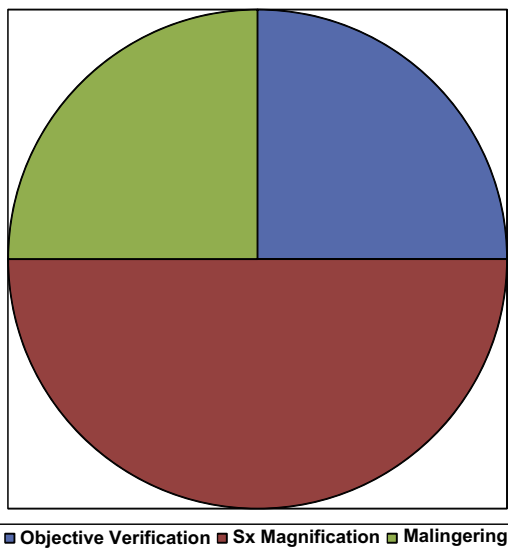


Fig. 1. Among dizzy patients involved in litigation, objective verification of symptoms is found in approximately 25%, nonphysiologic results suggesting frank malingering in roughly 25%, and exaggeration of symptoms in about 50%.

Assessment of Causation

Once the evaluation of the objective pathologic condition has been performed, causation must be considered. The legal hurdle for most expert witness testimony is the determination of probability. Probability is defined as more than 50% likelihood; consequently, absolute certainty is not required when determining causation, although it is best to be more certain than not. Remember, anything is possible, but the courts want to know what is probable.

Two factors that need to be considered are the timing and mode of injury. Timing refers to the time sequence of events in question relative to the pathologic condition causing the litigant's dizziness. Mode of injury refers to the mechanism, such as blunt head trauma, noise trauma, and explosion. Obviously, in a patient with immediate onset of vertigo after a sledgehammer impacted his occiput, both the timing and mode of injury would seem reasonable to accept as more probable than not, the head trauma is the cause of the vertigo. However, if you later find out that the patient did not have any vertigo or dizziness until 1 year after the sledgehammer incident, you would likely conclude that the vestibular problem was more probable than not to be unrelated to the head trauma. Similarly, for a situation in which a plaintiff complains of dizziness immediately after a tap on the shoulder, one might reasonably conclude that although the timing might be appropriate for causation, the mode of injury is inconsistent with the pathologic condition observed. Consequently, one would accept as more probable than not, that the shoulder tapping did not cause the dizziness. The 2 main questions to be answered are the following:

1. Is the mechanism of trauma appropriate for the injury?
2. Is the timing appropriate to link the pathologic condition to the alleged incident?

A word of caution is that it is inappropriate to take the patient's (or the attorney's) word for the mechanism of injury. You are the expert, and it is your job to make this determination. Both the patient and the attorneys (defense and plaintiff) have a significant stake in the outcome of your determination. Remain objective and verify anything you are told with objective findings, such as the medical record or test results.

Prognosis

After determination of the objective pathology, causation, and probability, the next step is determination of the prognosis. In this regard, you need to consider the average, that is, the best and the worst-case scenarios. You also need to consider sequelae that may be many years in the future. For the patient who has been seriously affected, this litigation may be their only chance for monetary recompense. The basis for the plaintiff's award is entangled in the prognosis. Any future medical and nonmedical needs should be considered. A recent conversation with a plaintiff's attorney was enlightening. I had seen his patient and treated her benign paroxysmal positional vertigo (BPPV). I informed him that he had a good case and that his client was already cured. He took this information as a good news/bad news moment. He had a good case, but because the client was cured, there would be little monetary award for future medical or other needs.

Dealing with Lawyers

Many physicians mistakenly believe that attorneys who hire an expert want that expert merely to support their case, a "hired gun." Although this belief may be true for a small minority of attorneys, our experience has been quite the opposite. Some of the most thankful attorneys were the ones to whom we had to give bad news. Plaintiff attorneys

sink a lot of their own money into their cases, and the amount of money invested is often substantial. The last thing a plaintiff attorney wants to do is to get all the way to a trial (read: large outlay of his own money on an expensive court trial) and then finally find out that his client is malingering. Similarly, a defense attorney who finds out that the plaintiff is legitimate and will likely win at trial is much more willing to offer a generous settlement in pretrial negotiations rather than risk losing at trial.

HISTORY AND PHYSICAL EXAMINATION

Our evaluation of litigating patients starts with an extensive questionnaire as mentioned earlier. This questionnaire is reviewed during the case history interview in order to clarify any points that may have caused some confusion. Some important points to identify during the history are the following:

1. Details of the alleged trauma or inciting event
2. Time course for onset of symptoms
3. Important associated events
4. Progression of symptoms
5. Evaluation and therapeutic interventions used
6. Prior history of dizziness, vertigo, tinnitus, hearing loss, or other otologic diseases
7. Extensive medical history including:
 - Surgical history
 - Significant medical illnesses
 - Hospitalizations
 - Medication use
 - Prior trauma
 - Alcohol, tobacco, and drug use
 - Occupational history including military history, criminal convictions, and prison stay
 - Family history.

The physical examination must include a complete head and neck examination as well as an extensive neurotologic examination. Specifically, this examination should include microscopic otoscopy, documentation of facial nerve function, global neurologic examination, and eye examination using infrared videography. The eye examination should include examination of ocular movements and examination for spontaneous nystagmus (with and without visual fixation) in all cardinal positions of gaze. Headshake and head thrust maneuvers should also be performed. Some physicians perform Dix-Hallpike testing during the physical examination, whereas others reserve this component for the formal electronystagmographic (ENG) or videonystagmographic (VNG) examination. The neurologic examination should include tests of the cranial nerves, cerebellar function, Romberg test, Fukuda test, and gait analysis.

Refer to the authors' "Dizziness Questionnaire" from The Ear and Balance Institute in the Appendix in this publication.

TESTING

As mentioned, objective testing is mandatory in cases involving litigation or other situations with potential for a secondary gain, such as worker's compensation or disability claims. Before objective testing is performed, there are 2 requirements: equipment calibration and properly trained ancillary personnel. If either of these is not present,

you cannot rely on the test results. Many physicians depend on their audiologists for the laboratory assessment of vestibular function. Whereas many audiologists are quite good at vestibular testing, others have had limited vestibular educational exposure and limited experience with vestibular testing. If this is the case, appropriate continuing education and training are required.

Audiological Testing

Audiometric evaluation should include a comprehensive audiogram, including air conduction and bone conduction testing (regardless of how good the hearing seems to be), speech audiometry, tympanometry, and acoustic reflex testing. Appropriate validation tests (eg, Stenger test) should be performed when there is a significant hearing asymmetry between the ears. One should take note of the pure tone average (PTA) in comparison to the speech reception threshold (SRT) in that there should be less than 6 dB difference between the PTA and SRT. In addition, the sound level of conversation at which the patient is instructed in the audiometric test booth should not be lower than the PTA or SRT. Other factors that should be noted include whether the patient reported hearing unmasked bone stimulation appropriately, whether the patient responded with “half spondees” (eg, the patient is requested to repeat the word “baseball” and replies “base....something”), whether bone conduction responses were present at higher sensation levels than air conduction responses, and whether acoustic reflexes were present in an ear that was reported as having profound hearing loss or conductive hearing loss. The physician should ask the individual performing the audiometric tests for a general impression of patient performance as well as the level of cooperation and reliability. Finally, the pure tone pattern should be assessed for physiologic character suggesting an organic pathologic condition or a non-physiologic pattern. In addition to the above-mentioned audiometric testing, we strongly advise that any abnormality should be corroborated by otoacoustic emissions and auditory evoked potential testing for threshold. We also find that adjunct testing, such as electrocochleography, is helpful in objectively identifying the pathologic condition. However, the decision to include such testing should be laboratory-specific and depends on the reliability of that particular laboratory’s experience with the testing.

Vestibular Testing

Vestibular testing should include a comprehensive analysis of all aspects of the vestibular system that can be evaluated objectively. Current technology allows assessment of vestibular responses with a variety of stimuli. Among these, a bare minimum would include ENG/VNG, rotary chair testing, and computerized dynamic posturography. Additional studies that may prove to be helpful would include vestibular evoked myogenic potentials and high-frequency vestibuloocular reflex (VOR) testing. Throughout these tests, the clinician should look for patterns consistent with known pathologic conditions and should be suspicious of poor results, unusual results, or failure to obtain any result at all. Poor cooperation should be noted. The clinician should also keep in mind that all these tests can be separated into 2 categories determined by whether the response is voluntary or involuntary. A common mistake for inexperienced clinicians is to interpret abnormalities on the oculomotor tests as being evidence of central vestibular dysfunction. Although this interpretation may be true, one should keep in mind that these tests require the patient’s cooperation and that abnormal results could also be the result of poor cooperation or malingering on the part of the patient. The clinician should be especially suspicious in cases in which the patient gives non-physiologic results in any of the testing protocols. Input from

the individual performing the vestibular assessment can be very helpful in cases in which results vary significantly from the norm. It should be considered standard for the examiner to report any erratic behavior of the patient or deviation from the test protocol. These patients should never be left alone in the examination or testing rooms, and ideally, a clinic chaperone should be present as a witness to all events that take place. We have also used video recording in various locations throughout our office. This evidence helps to eliminate contrary claims of patient experiences while in our office.

Imaging

We think that imaging (both high-resolution computed tomographic [CT] scan and magnetic resonance imaging [MRI]) should be performed in all cases involving litigation. Because the history may not be as straightforward as we would like, a detailed analysis of the inner ear and skull base anatomy is often elucidating. Consider the example of a patient who falls in a big-box store claiming hearing loss and balance dysfunction as a result of the fall. She has a CT scan of temporal bones that does not show any abnormality and an audiovestibular testing that demonstrates unilateral hearing loss and unilateral vestibular loss. The patient claims that the hearing loss and balance dysfunction occurred immediately after the fall. It would be easy to concur that the fall caused this patient's problem had you not ordered the MRI scan that shows a 3-cm acoustic neuroma in the affected ear. Yes, the hearing loss could have occurred when she fell, although this seems unlikely. Even so, the fact that she has a 3-cm acoustic neuroma in the affected ear certainly changes the complexion of the entire case.

REVIEW OF MEDICAL RECORDS

Medical records should be reviewed whenever possible. We find that the most helpful information is anything having to do with testing that gives objective results and almost any information before the event that is being litigated. Review of the police accident report, emergency medical technician report, emergency room report, and initial hospitalization can provide information that many patients may not remember. These reports can also be used to corroborate the patient's history as well as to corroborate any information that is provided by the attorneys. It is wise to exhaustively review the pertinent medical records before any courtroom testimony.

MALINGERING

Malingering is the false and fraudulent simulation or exaggeration of disease, performed to obtain money, drugs, evade duty or criminal responsibility or other reasons readily understood from the individual's circumstances, rather than learning the individual's psychology.⁴

Although a patient may be suspected of malingering, malingering is only part of the differential diagnosis in such cases. Remember that non-physiologic test results can also be otherwise explained. Alternative explanations include technical malfunction of equipment, poor understanding of the requirements of the test (as would be seen in young children and those with a mental illness), and panic disorder. In your capacity as an expert witness, it is better practice to avoid the formal diagnosis of malingering and instead expound upon whether or not the patient meets the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)* (DSM-IV) criteria

for malingering. After that, the judge and jury will decide whether malingering is an appropriate explanation of the litigant's behavior.

Malingering is suspected if any combination of the following DSM-IV criteria for malingering⁵ is observed:

1. Medical/legal context of presentation
2. Marked discrepancy between the person's claimed stress of disability and objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of antisocial personality disorder.

Malingering by Imputation

Many think that the most difficult form of malingering to encounter is malingering by imputation. In this case, the litigant has a legitimate pathologic condition and is very consistent, cooperative, and honest in dealing with the clinicians, that is, with the exception of 1 or 2 details leading to the causation of the pathologic condition. In general, the only way to identify this type of malingering is by a thorough review of the existing medical records. Even so, litigants, being aware that this review is a liability to them, may have worked hard to conceal any prior records identifying the pathologic condition as a premorbid condition. When the individual is not forthcoming with regard to a condition that is eventually identified, it is likely to be a case of malingering by imputation. On the other hand, a patient who is forthright about a prior condition and claims worsening of this condition by the event that is being litigated presents a situation that is not so straightforward. The question then becomes whether the alleged incident did indeed worsen the pathologic condition, which becomes a judgment call by the clinician dictated by the specifics of the case. Of course, admission of the premorbid condition will likely reduce monetary rewards on behalf of the plaintiff.

Red Flags

Certain findings should be red flags for the clinician to raise suspicions of malingering or symptom exaggeration regarding plaintiffs complaining of dizziness. Obviously, this includes the finding of nonphysiologic test results, but there are also more subtle issues to consider. The patient who either refuses testing or is unable to complete testing should raise suspicions. In our experience, we rarely encounter a non-litigating patient who cannot complete testing, and, in general, the more severely affected the patient the more motivated is he or she to complete testing. When the symptoms seem too severe for the disorder identified, one must consider whether exaggeration of symptoms is occurring. Frequent falls should raise suspicion of malingering or exaggeration. Although falls are the concern for patients with dizziness, vertigo, and poor balance, frequent falls are not commonly found in patients complaining of dizziness with no potential for a secondary gain. Patients may have 1 or 2 falls and then generally recognize this tendency. Subsequently, adaptations are made by either avoiding situations likely to cause falls or by taking other measures, such as the use of a cane or walker, to aid balance. Similarly, patients with episodic vertigo are typically mindful of their safety and use fall-avoidance behaviors at the first signs of vertigo. Difficulty in categorizing the plaintiff's complaints with a diagnosis should also cause some unease among clinicians. Patients who malingering or exaggerate tend to defy diagnostic categorization. And of course, behavioral inconsistencies such as lies, obvious exaggerations, and poor cooperation should certainly raise the

specter of malingering in the mind of the clinician. Remember that those who will lie to you over small things will certainly lie to you over big things. There could be legitimate explanations for all the abovementioned findings, but if any of these are present, a good explanation for their presence is warranted.

What not to miss

Obvious nonphysiologic test results
Patient who refuses testing or is unable to complete testing
Frequent falls with no attempt to report them or take measures to avoid them
Behavioral inconsistencies from the patient.

THE “NORMAL EVALUATION” PATIENT

Another vexing situation is the normal patient, a cooperative, reliable patient with a plausible history but normal findings on all of the objective tests performed. Because there are no objective findings on testing or physical examination, the entire case rests on the credibility of the patient. In our experience, patients in this category are more likely to represent the true pathologic condition. We must remember that all currently available vestibular tests only evaluate a small portion of the vestibular system. Consequently, it is not unreasonable to envision a patient who has pathologic condition outside the bounds of conventional testing. Vestibular function and symptoms can also fluctuate. Keep in mind that the test findings are a snapshot in time of that patient’s vestibular status, allowing for the possibility of a normal evaluation in a patient with a vestibulopathy. If one doubts this, consider the case of BPPV. One of the major characteristics of BPPV is fatigability, the phenomenon in which repeated testing of a positive result becomes negative. When patients have an abnormal result during the Dix-Hallpike maneuver, there is no doubt that they have BPPV; however, it cannot be determined with certainty that a patient with normal results during the Dix-Hallpike testing does not have BPPV. In the latter scenario, the patient may have BPPV that has already “fatigued.” For someone suspicious for BPPV with normal Dix-Hallpike results, repeat testing is recommended. Our recommendation for the patient in litigation is similar, repeat testing.

ASSUMPTIONS/PEARLS***Your Work and Your Credentials Will be Scrutinized***

As an expert witness, you must be prepared to explain your findings and conclusions, knowing that the opposing attorney has hired an expert who will be reviewing your work. Alternative explanations of your findings will be brought forth, and you will need to expound upon whether these theories are more or less likely than your conclusions. Many physicians find it unsettling for their diagnoses and conclusions to be questioned. However, such questioning is the rule rather than the exception when litigation is involved. Many experts will have scientific publications within the area being litigated. You can rest assured that a good opposing legal team will have reviewed your publications and any deviation from your prior opinions will make your testimony seem suspect. You may be required to explain excerpts from your prior papers that are placed out of context. In addition, your qualifications as an expert will be routinely examined and scrutinized by the attorney who hired you (usually before you are hired) and by the opposing counsel (at your deposition). Again, while this examination and scrutiny is unsettling for some, it is routine for expert witness work.

Never Assume Any Prior Diagnosis is Correct

Frequently, a prior diagnosis is assumed to be correctly made and is used as a shortcut to treat the patient. Whereas this is not good practice in general, it is a big mistake in the face of litigation. Physicians who examined and diagnosed the patient previously may not have been aware of any potential for secondary gain and accepted the patient at their word rather than objectively documenting any pathologic condition. Consequently, their prior diagnosis may have been made based on faulty information.

Cannot Assume a Normal Premorbid State

As mentioned earlier, you cannot assume that the patient had a normal premorbid state. A review of existing medical records is important in this regard, in search of past history of ear-related problems, dizziness, and associated testing. Only if there is no prior documentation can one infer that no prior pathologic condition existed. Even in this scenario, however, many patients will have pathologic condition of which they may not have been aware. We find that the most common example of this is noise-induced hearing loss. Easily identified by the 4 kHz notch on the audiogram, this pathologic condition creeps up on patients slowly and in its early phases may not present with symptoms. If noise-induced hearing loss has no reasonable association with the alleged injury, it is likely a premorbid state.

Appropriate Referrals

Pathologic condition outside our areas of expertise should be evaluated by the appropriate professional. Extreme reservation should be used in giving expert opinions in areas outside of one's specific field. For example, a common complaint among patients with closed head injury is cognitive dysfunction. A neuropsychology referral is warranted to quantify this issue objectively and to separate organic pathologic condition from nonorganic causes. Similarly, anxiety and panic disorder should be referred for appropriate treatment.

Financial Incentives Obscure the Picture

It is helpful to understand the financial motivation of all parties involved in litigation. The easiest to understand is that of the plaintiff, which is monetary recompense for the alleged injury. The expert witness must always keep in mind this bias and how it may result in exaggeration or malingering. The defense obviously wants to avoid any payout to the plaintiff and is in direct conflict with the plaintiff. The defense attorneys, while wanting to make a good defense, are usually paid on an hourly basis and have an incentive to drag out the proceedings as long as possible regardless of the outcome. The plaintiff attorneys are more interested in shorter proceedings because they typically invest their own money into the case and do not have unlimited resources for a protracted litigation. In fact, unless a case can win a certain sum of money, regardless of the case's merits, a plaintiff attorney may either decline a case or become very passive in its prosecution. In any event, many more cases settle out of court rather than proceeding to trial.

Litigation May Become Protracted

If you are acting as an expert witness, you need to prepare yourself for the possibility that your services may be required for one case many years after the fact. Both authors have been involved in cases that have taken beyond 10 years to resolve. It is not unusual for litigation to spawn additional litigation or repeat lawsuits. It seems that some litigants become "frequent flyers" in the court system.

Be Prepared to Change Your Opinion as New Evidence Arises

Sometimes when you are evaluating a patient in the context of litigation, you are not privy to all the information concerning the plaintiff. Because of an inevitable bias of either side in the litigation, your opinion may be swayed by information informally relayed to you that you eventually find out is not correct. Consequently, a change in your opinion during the course of evaluation may be warranted. There is no reason that an expert witness cannot change his opinion as new evidence surfaces. In fact, the merits of the case should be re-evaluated and a new opinion produced when any new pertinent evidence arises. This situation is more common than many realize.

Payment

Although many physicians are uncomfortable discussing fees, it is important to be upfront about your fees when dealing with any case involving litigation. If at all possible, you should have a signed contract with the attorney who has hired you before seeing the patient. This contract should detail all your fees, including office visits, testing, reports, phone conferences, depositions, and trial appearances. Because the time, effort, and intellectual energy expended in these cases are considerably more than those with routine patients, one should not accept discounted Medicare or insurance rates for the clinical components in the evaluation of these patients. It is advisable to require payment in advance for your services and to decline cases with contingency fees. Accepting a contingency fee for a case compromises your impartiality and credibility and is unethical. While depositions can be scheduled at your convenience, trial appearances cannot. Providing courtroom testimony will typically absorb most, if not all, of your working day and more than a day if there is any significant travel involved. More trial appearances will be scheduled than actually occur because many cases settle at the last minute. Because it is difficult to reschedule a clinical day at the last minute, payment in advance and a cancellation fee are reasonable approaches for such occurrences.

CONCLUSIONS ON EVALUATION OF THE DIZZY PATIENT IN LITIGATION

Evaluation of the dizzy patient who is involved in ongoing litigation is a challenging endeavor. However, recognizing the challenges and appropriate management of these patients, in addition to the legal entanglements associated with them, can lead to a fruitful endeavor. The role of the physician in this situation is not that of a patient advocate but rather of an agent of the court in pursuit of a truthful unbiased analysis of disability, causation, and prognosis.

What not to miss

- Physician as agent of the court
- Extensive documentation of history and physical examination
- Extensive objective verification of complaints
- Extensive objective testing to exclude other pathologies
- Corroboration of objective and subjective findings
- Assessment of disability, causation, prognosis, and future needs
- Evaluation of possible malingering or exaggeration.

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