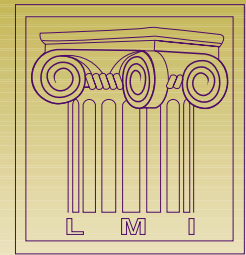


M.I.M.

R E P O R T E R



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Medical Information Management in Diet Medication Litigation

by Elizabeth B. Juliano and James R. Fell

Part I - Primary Pulmonary Hypertension

Introduction

Amid mounting reports of serious medical conditions associated with intake of the weight reduction medications dexfenfluramine (Redux), fenfluramine (Pondimin), and phentermine (Adipex, Fastin, Ionamin), the legal profession has been tasked to fully comprehend claims of morbidity and mortality attributed to these products. Much of this challenge arises because many of the published clinical reports on these preparations originated as recently as 1997, and then consisted primarily of correlation studies. Scientific research has yet to prove a definitive causal relationship between these products and the alleged medical syndromes. Therefore, structuring medical analysis in diet medication litigation can be difficult.



A second challenge for attorneys litigating diet drug cases arises in understanding the clinical aspects of the various medical claims. The normal incidence of some of the named disorders is relatively rare, and consequently, medical professionals may have limited experience in their recognition and treatment. Furthermore, findings of *in vivo* studies on the possible negative effects of these preparations are just beginning to be published. Toxicological evidence on any harmful effects of these medications continues to be evaluated.

This manuscript is the first in a series that will outline cost-effective methods to manage medical record acquisition, review, and analysis in diet medication litigation. Because a mass tort often evolves from a series of individual lawsuits, the need for a medical information management program may not be totally apparent until cases are in discovery and trial dates have been set.

Therefore, successful medical case management for such litigation depends upon proactive strategic planning versus a reactive approach.

Scope of the Review

In cases of emerging mass litigation involving medical issues, the prevailing practice has been to acquire and review in detail all plaintiff healthcare records. A sweeping record review in such litigation is justified on grounds that a complete analysis of all plaintiff medical records may yield evidence that would suggest alternate causation(s) for the allegations of injury, as well as additional valuable information.

IN THIS ISSUE

- ❖ Medical Information Management in Diet Medication Litigation (Part 1)
- ❖ Further Advice on Medical Record Acquisition
- ❖ Reviews of *Neurolaw* and *Void Where Prohibited*

This newsletter was prepared by the Corporate Education Division of Litigation Management, Inc. For more information about any of the articles in this newsletter please call James Fell, Director of Corporate Education, at (216) 621-2287 or 1-800-778-5424; Fax: (216) 621-8341. Questions may also be directed to the newsletter e-mail address at contactlmi@litigation-mgmt.com.

Global record reviews are also required in developing medical class actions where an “alphabet soup” of allegations comes to involve all major body systems. In such litigation, costs associated with this intensive medical record analysis quickly mount because of management fees connected with record acquisition, duplication, and professional review of shear volumes of information.

Medical information management in diet medication litigation presents a somewhat different scenario as the allegations tend to be focused in specific areas. To date, epidemiologic investigations have focused on two principal concerns associated with the intake of selected diet medications—primary pulmonary hypertension and cardiac valvular disorders. Further allegations have been related to the development of neurological disorders, psychiatric disturbances, and birth defects. Existing medical conditions, such as glaucoma, have been allegedly exacerbated by some of these products. Additionally, when consumed in combination with certain other medications, life-threatening reactions may occur as an outcome of diet medication intake.

Primary Pulmonary Hypertension

Primary pulmonary hypertension (PPH) is the pathological development of elevated blood pressure in the arterial blood vessels in the cardiopulmonary circulation loop. Under normal conditions, blood pressure in this loop is relatively low when compared to the pressures required to profuse blood in the larger systemic loop of the trunk and organs.

PPH manifests itself through injury to the endothelial cells lining the pulmonary blood vessels. This damage leads to an increased state of vasomotor tone (the muscles of the blood vessels contract more than is necessary) resulting in a decrease in the diameter of the blood vessel “pipeline.” Blood vessel lumens further decrease as the tissues comprising the vessel walls overgrow, thicken, and scar. To compensate, the heart contracts harder leading to increased pulmonic blood pressure and eventual heart failure.

Normally, the incidence of PPH is extremely low, about 2 cases per million. Because PPH displays few specific early warning symptoms, diagnosis of the disease is often delayed.¹ The mortality rate in any diagnosed PPH is quite high, with lung transplantation and a limited number of medications the only effective treatments.

The etiology of PPH is often unknown. It has been linked to chronic obstructive or interstitial fibrosing lung disease; collagen vascular disease, such as scleroderma; cirrhosis and portal hypertension; HIV infection; genetics; cocaine abuse; oral contraceptive intake; and recent pregnancy.^{2,3} Obstructive sleep apnea (itself a problem in obesity) has also been listed as a possible etiology.⁴

An alarming increase in the incidence of this disorder had been observed in the 1960’s among individuals who consumed one diet medication, aminorex fumarate. In the early 1990’s, development of PPH was associated with fenfluramine derivative intake. A 1996 study once again noted a possible connection between intake of certain appetite-suppressant medications and the onset of PPH.⁵

Medical Record Review

In diet medication litigation involving claims of injury linked to the development of primary pulmonary hypertension, the review should focus on the following medical documents:

Hospital Admission and Discharge Summaries.

These reports provide concise overviews of the contents of the larger medical record and serve to structure and focus the analysis of the entire record. The medicolegal analyst should focus attention on all cardio-respiratory evaluations and findings.

Physical Examination Reports. In its initial stages, PPH is generally asymptomatic. Because of this, analysis of physical examinations may fail to reveal any documentation of emerging difficulties associated with this diagnosis. Gradually, shortness of breath will manifest itself and progressively limit the degree of functional activity for the patient. The appearance of fatigue, chest pain, peripheral edema (fluid accumulation and swelling in the extremities), peripheral cyanosis (dark blue discoloration of the extremities), and syncope (fainting) may be recorded. Auscultation of the heart may note alterations in cardiac sounds indicative of blood regurgitation through the tricuspid and pulmonic valves.⁶

Physician Progress Notes. To ascertain if adequate medical monitoring was implemented for plaintiffs undergoing diet medication therapy, all physician and physician extender (nurse practitioner, physician assistant) progress notes should be reviewed. Records should reveal that a plain-

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tiff undergoing therapy was routinely evaluated for the onset of respiratory symptoms. However, in the case of PPH, the emergence of a classic warning sign—shortness of breath—can be a poor predictor of developing problems in an obese individual with poor physical conditioning,⁷ and accordingly, the patient may not have undergone extensive medical evaluation until subsequent symptomatology was manifested.

Nursing Notes. The typical hospital record contains voluminous quantities of nursing notes, whose acquisition and review can add considerably to the expense of medical analysis. Fortunately, in diet medication litigation initial attention need be only directed to a study of the nursing admission and discharge summaries, which should adequately document any pertinent physical assessment findings.

Laboratory Reports. Serum chemistries, blood cell, liver function, and coagulation studies should be evaluated as to their significance in the medical allegations. Arterial blood gas reports have importance in the assessment of hypoxemia, dyspnea, acid-base imbalances, and other pulmonary conditions.

Diagnostic Procedures. Findings and diagnoses from all the following evaluative studies should be reviewed *in toto*:

Echocardiogram (ECHO). The transthoracic or transesophageal Doppler flow ECHO and Doppler ultrasound are indicated to assess the etiologies of PPH. ECHO can provide an estimation of actual pulmonary artery blood pressure, as well as detecting another PPH condition involving enlargement of the right ventricle of the heart. In this state, a corresponding decrease in the size of the chamber of the left ventricle can then produce a distorted interventricular septum (wall dividing the two ventricles)⁸ leading to heart failure.

Electrocardiogram (EKG or ECG). This study of electrical activity of the heart can also reveal right ventricular hypertrophy that could possibly be symptomatic of PPH.⁹

Cardiac Catheterization (CC). CC involves insertion of a small tube directly into the heart via venous access and can document findings relative to blood pressures in the heart chambers and associated large blood vessels. In PPH elevated pulmonary blood pressure and increased pulmonary vascular resistance can be detected through this test.¹⁰

Chest X-Ray (CXR). A chest x-ray may be the only pre-morbidity pulmonary diagnostic study on most plaintiffs. Prominence of the right ventricular outflow vessels has been observed in PPH on CXR,¹¹ although the lung fields themselves may actually be clear.¹²

Pulmonary Function Test (PFT). The PFT is a lung volume study that measures the efficiency of air exchange into and out of the lungs. In PPH a mild restrictive pattern may

be noted.¹³ However, in extreme obesity, findings from PFT testing can be compromised by the pressure of excessive adipose tissue that can significantly increase the effort of breathing.

Ventilation-Perfusion Lung Scan. This test is mainly utilized to diagnose pulmonary embolism (a blood clot that is clogging an artery). While a published report describing findings of this scan in a case of PPH listed no abnormalities,¹⁴ situations may be encountered in medical record review where the patient was evaluated through application of this study.

Chest Computed Axial Tomography (CT or CAT). A thoracic CT scan photographs “slices” of the chest region and can be useful to diagnose changes in vascular structures.

Autopsy Reports. Death and autopsy reports should be closely reviewed for findings on pulmonary examination. Autopsy reports should note which organs and tissue were selected for further pathologic study, and the disposition of these specimens. Records warranting examination include:

Gross Pathology Reports. Examination of the respiratory system should note the presence of abnormalities in pulmonary vasculature and the air exchange structures of the lungs. Cardiac dissection should note the presence of ventricular enlargement and any septal displacement.

Histopathology Records. Microscopic analysis of tissues removed from the deceased’s respiratory system ideally will have been conducted by a pathology specialist, versus a generalist, in cases of PPH. If a specialist was not originally available to perform such a study at the actual time of death, slides and preserved tissue specimens should be acquired for further analysis by the attorney’s own medical expert. One published autopsy report in a case of PPH noted the presence of alveolar edema (fluid accumulation in the minute air sacs in the lungs) and congestion. Plexiform arteriopathic lesions (pulmonary artery sclerosis) were widely observed, while the pulmonary veins were normal (as would be expected in a hypertensive state).¹⁵

If the next of kin refused an autopsy request, this should also be documented in the medical record, along with any stated rationales.

Medicolegal Analysts

Primary pulmonary hypertension is rarely seen in a normal patient population, and most medical practitioners will have had limited experience with this disorder. Therefore, law firms should be highly selective in the retention of medical information management professionals to review these cases. In addition to possessing advanced education and specialization in pulmonary medicine, the medicolegal analyst

should also evidence specific experience in the direct evaluation and treatment of PPH.

References

The next issue of the *M.I.M. Reporter* will discuss medical information management strategies for review of allegations of cardiac valve disorders associated with diet medications. For further reading, a comprehensive edition of "Medical Information Management in Diet Medication Litigation" (presently undergoing peer review by a national legal journal) may be accessed through the Litigation Management, Inc. web site at: www.litigation-mgmt.com.

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11. *Ibid.*
12. Harrison's, 1467.
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14. Mark, et al. 602.
15. *Ibid.* 603.

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Coming Up in Future Issues

- ❖ Medical Information Management in Diet Medication Litigation (Part 2)
- ❖ Decision Factors in Outsourcing Medical Information Management
- ❖ A Paradigm Approach to Medical Information Management in Toxic Torts

Paralegal **Tips** and **Timesavers**

Medical Record Acquisition: Locating Healthcare Providers (Part I)

As noted in the previous issue of the *M.I.M. Reporter*, the success of obtaining medical records in a timely fashion depends, in many instances, on the accuracy of healthcare provider information documented in the completed interrogatories/questionnaires. This first in a series of two articles will detail resources available for locating these providers and, more importantly, the records in their custody.

To effectively manage time and contain costs in record acquisition, the paralegal should first define a standardized protocol for locating physicians and/or hospitals. Upon receipt of plaintiff-provided answers to questions regarding healthcare providers, a thorough review must be performed to determine the relevance of all information garnered. In most medical litigation, the paralegal will be selective in deciding which medical records to request. A brief consultation with a medical information management specialist can yield significant dividends in targeting only pertinent medical documentation and avoiding unnecessary expense associated with the acquisition process.

In the usual situation, the paralegal will be prioritizing the healthcare providers in order of importance for record receipt. The highest priority should be given to those healthcare providers most intimately connected with the alleged complaint or the incident identifying the alleged complaint. As further discovery transpires, it may or may not become necessary to locate these documents.

Earlier it was recommended that a tracking mechanism be developed as

one component of a case management program. During the search for demographic information on a healthcare provider, it is important to document the steps taken, the parties called, and the names of any contacts. This information is always useful for future reference as well as documentation in the event that the provider falls into the category of "unable to locate."

Reference Media

Four basic choices are available to locate healthcare providers: hard copy references, electronic formats, direct telephone contacts, and professional boards/associations. Hard copy references are directories which detail information about physicians, group practices, hospitals, clinics, healthcare systems, and other providers of care. Electronic references consist of CD ROMS and the Internet. Examples of telephone contacts include directory assistance, former partners in a group practice, the successor of a physician's practice, and medical staff offices. Medical and professional specialty organizations constitute the final reference resource.

Hard Copy References

One of the best sources of hospital and healthcare systems information is *The Hospital Phone Book*, compiled by U.S. Directory Service [USDS]. The cost is approximately \$119.95 and may be obtained by calling 800-521-8110. The directory is published annually and is divided into three major sections. The first section provides information on zip codes, state abbreviations, area codes, and healthcare help and hotlines. Sec-

tion two is a listing of hospitals by state and city and provides, in addition to name, address, and telephone numbers, the type of facility and the bed capacity. The third section is an alphabetical listing of all 7,300 facilities.

Another good resource for hospital information is the *Official National Hospital Blue Book* published by Billian Publishing Inc. The cost is approximately \$249.00 and may be ordered by calling 800-533-8484. The Blue Book also is an annual publication, and in addition to hospital information organized by state, there is a section identifying healthcare systems and affiliations. This reference is very helpful in that mergers and acquisitions many times create a name change of which a plaintiff may be unaware. The *Blue Book* offers detailed information about various departments within the facility which is useful in identifying the director of Health Information Services [Medical Record Department]. Additionally, there is a listing of medical schools and a glossary of healthcare/hospital-related terminology.

Physicians who are presently practicing medicine and some recently retired physicians can be located in the *Directory of Physicians in the United States*, published by the American Medical Association. The four-volume directory contains 723,000 listings and may be obtained by calling the AMA at 800-621-8335; the cost is approximately \$545.00. The directory contains Medical Doctors (MD) and Doctors of Osteopathy (DO). This resource is also available on CD ROM at approximately \$745.00.

Paralegal Tips and Timesavers

Telephone Resources

Locating physician demographic information is challenging when the physician is retired, deceased, or has re-located. Many physicians sell their practice upon retirement and, if the patient continues his care under the successor, the new practitioner will assume custodial responsibility of the patient's medical record. Some retiring physicians will not sell their practice, and, by law, should notify each patient that his/her medical record will be destroyed if not requested within a certain time-frame. This sometimes results in medical records being stored in a retired physician's home or a storage facility. This is where detective work is sometimes necessary. If the city of residence or last known residence is available, the paralegal should try directory assistance, requesting both business and residential listings. On occasion, a relative with the same last name may be located who is able to provide direction as to the location of the retiree and/or the medical records. Out of date reference books such as telephone directories, hospital and clinic directories sometimes provide clues, or at least a starting point.

Within the answers to interrogatories, one can usually determine the hos-

pital(s) where a physician maintained privileges. The medical staff services department within a hospital can be a wealth of information regarding physicians with current and past privileges.

Associations and Boards

National, state, and local medical boards and professional associations are excellent resources. All states have medical boards for medical doctors and osteopathic physicians, in addition to those boards which are restricted to medical specialties. The telephone numbers for these boards can be accessed via directory assistance. In preparing to contact a medical board or association, verify the complete accuracy of the physician name(s). Additionally, when an inquiry involves several physicians, it is advisable to combine the names under the auspices of one larger request.

Every licensed physician in the United States can be found in the database of the American Medical Association; telephone number 312-464-5000. A physician need not be a member of the AMA to be included. If the designation of a physician is known to be Doctor of Osteopathy, the American Osteopathic Association, telephone number 312-280-5854, may be contacted for demographic information. If the person completing the question-

naire indicates having been treated by a physician many years ago, one should be sure to relay this information to the board or association so that archives may be searched as well as current available data.

Conclusion

The investigation of healthcare provider demographic information is fairly easy when a protocol and database of information have been established, especially in the search for physicians. Upon finding a good source of information, be certain to document the name of the contact person, the hours of business, and any special requirements. The more expeditious the search, the shorter the turnaround time in obtaining medical documents.

Look for an upcoming issue of *The MIM Reporter* for tips on using CD ROM references and the Internet as further sources of provider information for the acquisition of medical records. Additional articles and information on medical record acquisition can be located on the Litigation Management, Inc. web site at www.litigation-mgmt.com.

Authors: Elizabeth Juliano
Karen Ness

Book Reviews

Donham, Kelley; Rautiainen, Risto; Schuman, Stanley; and Lay, Jan, Editors. *Agricultural Health and Safety: Recent Advances*. New York: The Haworth Medical Press, 1997. Hardcover, 428 pages. \$79.95

Urbanites who picture farm workers engaged in wholesome labors in pristine, pastoral settings will rapidly experience a dose of reality shock upon reviewing *Agricultural Health and Safety*. Potential medical hazards abound on the farm and range in scope from pulmonary allergens in airborne pig urine to musculoskeletal injuries associated with improper cow milking ergonomics. While medical litigation involving occupational illness and injury continues to remain

focused on the risks to workers in mining, manufacturing, and most recently, the business office setting, as this text illustrates, the traditional family farm can also be a very dangerous place in which to be employed.

Farming issues that include increased mechanization, rise of factory farms, and pressures linked with expanding economies of scale have conspired together so that agricultural occupational health has emerged as a significant public health concern. The editors of this text have reviewed the research studies presented at the 1996 NIOSH Agricultural Health and Safety Conference and have compiled these into a monograph that is clinically and scientifically instructive to

legal professionals engaged in a wide spectrum of agricultural litigation.

Agricultural Health and Safety contains many highly specialized, sharply focused scientific reports, and this book should be appreciated for the diversity of its overview. However, attorneys specializing in agrochemical litigation, such as those cases involving pesticides or fertilizers, will find a limited number of articles in their area of practice. On the other hand, personal injury and product liability attorneys may find the reports on equipment perils, including tractor rollover protection and stability standards, to be timely and informative.

Reviewed by: Elizabeth B. Juliano
James R. Fell

Linder, Marc, and Nygaard, Ingrid. Void Where Prohibited: Rest Breaks and the Right to Urinate on Company Time. Ithaca: Cornell University Press, 1998. Hardcover, 244 pages.

In his landmark conceptualization of human needs, Abraham Maslow, a developmental theorist, defined a hierarchy of physical and psychosocial elements regarded as critical to human life, self-fulfillment, and ultimate self-actualization. The foundation of this hierarchical pyramid consists of high priority, basic physiological requirements whose minimal satisfaction (food and water intake, elimination, temperature regulation, etc.) is essential to maintain basic biologic integrity. Unmet needs produce stress and can jeopardize the health of the human person.

Void Where Prohibited: Rest Breaks and the Right to Urinate on Company Time is both a legal and medical exposé of the increasing indignities endured by American workers whose employment life has come to be regulated down to the very physiologic level—the granting and timing of break time for body elimination needs. While federal and state regulations require employers to provide toilets in the workplace, incredibly, these same regulations do not require employers to permit workers to use them. Over time, bathroom breaks have become another commodity that has entered into the collective bargaining process.

This control over basic physiology in workers has come with a severe medical price tag. *Void Where Prohibited* notes how employees become mentally and physically conditioned to suppress the urge to void during working hours and consequently develop syndromes such as “nurse’s bladder” and “line-worker’s bladder.” This unnatural retention of urine can result in greater medical problems such as urinary tract infections and possibly even heart disease.

In an effort to comply with restricted rest break opportunities, employees may resort to drastic self-imposed restric-

tions on fluid intake, or even wear incontinence pads. One worker was noted as having spent one-tenth of her weekly salary on such devices. The outcome of such practices, according to the text, is that the American worker is infantilized back to his/her pre-toilet training period as a survival mechanism to cope in an overly oppressive workplace environment.

The denial of free access to bathroom breaks is especially pronounced in fast-paced, mass production enterprises. For example, in meat processing and other assembly line operations, if even one worker is temporarily absent from the processing flow, either the quality of the final product will be affected or the entire line must be halted until her/his return. Under some sweatshop working conditions, employees must raise their hands to request supervisory permission to attend to bathroom needs, or else wait until a replacement worker can be located to cover their workplace assignment. The text documents several cases in which fear of discipline and job loss became such overriding influences in a worker’s life that the choice was made to eliminate in one’s clothing versus leaving the assembly line.

Labor-management rest break disparity is a predominant theme through this book. In the name of professional development, company managers are typically self-authorized to browse the newspaper business pages while seated in the privacy of lavish executive toilet stalls. On the other hand, bathroom breaks of their employees may be timed by hand-held computer scanners and are taken in dramatically less plush environments.

American management’s perspective on regulation of rest breaks most likely has its origins in a Puritanism that regarded control of one’s physiology as “strengthening” or “character building.” However, the hypocrisy of this value system becomes apparent when it is applied only to laborers and not higher management elements. While management typically can eliminate “at will,” workers seeking “excessive” rest breaks are perceived as robbing the business owner.

Authors Marc Linder, a labor attorney, and Ingrid Nygaard, a urogynecologist, infuse tongue-in-cheek humor throughout their well-researched medicolegal and extensively footnoted essays on the rights of workers to eliminate on company time. While this text is highly entertaining to read, it also represents serious academic thought and effort. A study of *Void Where Prohibited* should be required for all managers and human resource personnel who unthinkingly formulate restrictive employment policies to increase productivity at the expense of basic workplace freedoms. Labor and employment attorneys also will find this book most applicable.

Reviewed by: Elizabeth B. Juliano
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Book Review

Taylor, J. Sherrod. *Neurolaw: Brain and Spinal Cord Injuries*. Clark Boardman Callaghan, Thomson Legal Publishing, Inc., 1997. Available through ATLA Press and West Group. Binder, loose-leaf. \$165 (ATLA members' cost is \$145)

Every year in the United States over 2 million individuals suffer some type of traumatic brain injury (TBI), and an additional 10,000 are afflicted with a spinal cord injury (SCI). Annually, millions of dollars are spent for treatment, rehabilitation, and custodial care of these victims. The impact of these injuries extends far beyond the striking loss of an individual's physical functioning including compromised earning power, reduced quality of life, impacted familial relationships, and continuing emotional distress. On the macro level, TBIs and SCIs impose significant fiscal burdens on governmental and private healthcare financing institutions.

Against this backdrop, *Neurolaw: Brain and Spinal Cord Injuries* represents a selected synthesis of medicolegal literature in the developing specialty field of neurolitigation. Author J. Sherrod Taylor, is a neuroattorney with extensive experience in personal injury and wrongful death cases. A former director of the Brain Injury Association and board member of the International Brain Injury Association, Taylor personalizes the text with "lessons learned" from what he terms "war stories" in the neurolitigation arena.

Taylor imposes clarity, precision, and consistency on medicolegal terminology applications in neurolitigation. The author notes that interchangeable use of labels such as "closed head injury" and "traumatic head injury" has unnecessarily confused neurolitigation, when the more accurate and specific nomenclature should be "traumatic brain injury." On the other hand, Taylor indicates that much greater standardization of terminology presently exists for spinal cord injury conditions, thus facilitating communication between attorneys and clinicians.

Taylor stresses the critical importance of developing a "theme" early in the course of the litigation, which serves to order both the construction of the case and to focus the attention of the jury. Adeptly and coherently argued, a theme

such as "quality of life" will effectively trigger reasonable empathy and concern on the part of the jurors. The author advises that by propounding additional related themes, including "injury," "recovery," and "liability," trial attorneys pose multiple avenues to resolve critical elements in the neurological case.

The extensive section on trial preparation includes perspectives on analyzing the nature of the injury, effective use of expert witnesses and demonstrative evidence, settlement considerations, and techniques of trial planning. The author notes that success in neurolitigation is highly dependent upon the identification and screening of expert witnesses encompassing a variety of disciplines spanning the spectrum from various medical professionals to life care planners and economists. Effective incorporation of expert testimony is discussed in light of the *Daubert* decision. In a subsequent section on the latest medical imaging and other evaluative techniques available to assess neurological damage, the text defines how these studies can supply powerful demonstrative evidence to illustrate the cause, nature, and extent of the plaintiff's injuries.

Conduct in a well-planned neurological injury trial is explained in sections detailing effective techniques for voir dire, opening statements, selection and preparation of witnesses, direct and cross examinations, and closing arguments. Key components of this process are illustrated through the incorporation of selected reference articles. Three such articles offer advice on persuasively conveying to jurors the pain and suffering experience that must be constantly endured by victims with these chronic injuries.

The introduction notes that *Neurolaw* was written by a plaintiff's trial lawyer for other plaintiff's trial lawyers. However, the strategies and tactics outlined in this work will have utility for opposing counsel and medical experts who must respond to these arguments. Whatever the readership, Taylor's grasp of the complexities of these sometimes difficult cases is presented in a practical format that is as absorbing as it is informative.

Reviewed by: Elizabeth B. Juliano
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