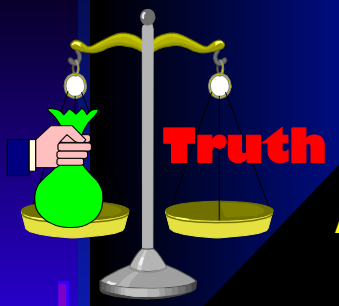
An Independent Examination of Independent Examinations:

An Independent Skinnerian Examination (ISE)?



American Academy of Pain Management
San Antonio, *September 9, 2004*

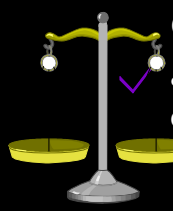
Michael F. Martelli, PhD
Concussion Care Center of Virginia & Tree of Life
Glen Allen, Virginia 23060

http://VillaMartelli.com

email: mfm@villamartelli.com

The doctor:

- ✓ Spent only one half hour with me and stuck me with a technician
- ✓ and used lowsy tests that noone I know believes in
- ✓ and talked mostly about why I didn't think I could work and if I ever went out on disability before, or if I was really emotionally disturbed, not hurt
- ✓ ...but spends hours and hours with the big shot decision makers
- ✓ ...and spent more time giving me trick (malingering) tests than talking to me
- ✓ ...and wrote a report that let SSD deprive me of the disability I deserve



Medicolegal Aspects of the IME

Civil Rule 35(a): IME of PI subject:

- Insurance Company Request (their selection, expense)
- Defendent (insurance) Request

Nature of Doctor Visits & IME's:

- Regular MD visits interently aversive to many (esp males, introverted, etc.)
- MD distrust (competence, interest) often high
- IME = Adversarial = Anxiogenic = amplifies Aversion, Neg Reactions, Disrtrust, Distress, Resentment...
- A Coerced Exam with a Stranger; a Non-informing, Non-accountable, Agent of Restriction

Insurance Medical Exams?

- I.M.E. Presumptions *(Explicit & Implicit)* of Insurance Co's
  - Doctor-Patient advocacy relationship produces bias that inflates estimates of impairment and treatment needs - *Sometimes True?*
  - Presence of Doctor-Patient Relationship reduces validity of assessment - *Unsupported and Arguable; Absence can seriously limit validity of information collection, active DX procedures, produce over-reliance on unvalidated and subjective record review prcedures, expose skepticism bias, etc*
  - Treaters have a "Need to Treat" Bias - *May be Less of an Instrument Bias than "Insurance Bias/ Rationalization"*
  - Treaters are more likely to be, incompetent and/or disabilty reinforcers/enablers *Probably Usually False; and Insulting*
  - Patient (treater) is trying to access undeserved entitlements
    - *cf: "Have Nots "trying to Steal from the "Haves"??* Cognitive Dissonance / Convenient Rationalization?

Disparage Enemy necessary to Justify/Excuse Restricted Benefits ?

Independent Medical Exams?

- **Purchasers of Insurance Medical Exams***
  - Motivation: Reduce "Occurrences"
  - Regulators: Actuaries, Public Relations
  - Growth Factors: CEO, Board
    - Recent Trend: Preemptive PR, Lobbying Campaign
      (Confirmatory Selection; Urban Legends; Promote Revulsion of Excesses in Treaters/Patients, Atty's & Lobbying for Tort reform, etc)
- **Results:**
  - Precipitous Decrease in Authorized Health Care Payments, and Regard for Health Care Treaters
  - Precipitous Increase in IME Utilization and Insurance ***Profits***, with Parallel Increase in Medicolegal Practice, Pubs, Talks, etc..
    - 11 major Insurers: Avg 47% Profit Increase, Q3, 2002
    - Premiums rise 15.4%; health costs only 12% (2003)
    - Uninsured: 7.2 M <16yo, 39.4M < 65, 2001 (20% US Pop)

- **Note: Oregon WCB Adopted this 'honest' name change**

Medicolegal Aspects of the IME:
Adversarial Exam and Critical Responses*

Plaintiff Atty Arguments. *Witness Would Ensure:*

- Justice: Exam not conducted "in secret" (ind. constitutional right to open court process)
- Justice: For insurance company required exam with selected, highly paid expert accountable only to them
- No inquiries into illegitimate scope matters
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- IME examiner's attitude, tone, behavior are professional
- Minimally invasive, as possible, consistent with case nature
- Monitor what questions asked, not, tests, not, etc.
- Reassure client re: procedures/ testing to prevent misinterpretation

**Why would anyone want to invade our assessments...*
or sit for 8 hours of testing?

ADVERSARIAL V SCIENTIFIC METHOD

Trial Attorney	Treating Clinician	Independent Examiner	Trial Consultant
Win Case Max/Min Award;	Clinical DX & TX -> Recovery	Independent DX, Infer Causation, Apportion	Assist Atty Advocacy
Adversarial Advocate	Dr - Pt Relationship Present Clin. Findings	Present Indep. Findings	Use Scientific Knowledge to Assist Atty Advocate
Best Advocacy	Competent Clin. DX & TX	Objectivty & Independence	Accurate Rep. Scientific Knowledge
Black/White Either/Or	Multifactorial	???	???

Perception Bias (magnet)

- We see what we look for. We look for what we know. - *Goethe*
- The theories we choose determine what we allow ourselves to see. - *Albert Einstein*
- We don't see things as they are, we see things as we are. - Anais Nin
- When we don't even believe that something is possible or that it exists, we fail to see it at all. - *Dorothy Otnow Lewis*
- For every complex problem there is an easy answer... And it is wrong. - *H. L. Menchen*
- "The tendency to organize knowledge around a belief system, and then to defend that belief system against challenge, appears to be a fundamental human characteristic...."

We See What We Look For,
We Look For What We Know
Goethe

Survey of Attitudes Regarding Workers Compensation

	Disability Evaluating Professionals (N=27)	Med. Psych Service (N=9)	Case Managers (N=16); 7 =W.C.	Neuropsy Psych, PM&R MDs (27)	W.C. Pts (N=22)
Question					
1: % of Injured Workers Who Exaggerate/ Malinger	19.2	24.7	28.5	19.2	35.0
2: % Injured Worker that W.C. Insurance Treats < Fairly	49.2	62.5	23.2	44.6	74.2
3: % Employers Who Treat Injured Workers < Fairly	53.5	41.2	32.7	36.7	65
4: Likelihood Employer Would Treat You (if injured) < Fairly	43.75	54.2	46.4	23.6	70.8
44.65: Likelihood W.C. Would Treat You (if injured) < Fairly	60	65.9	48.9	40.4	77.8
IV-3: Sex	66% Female	57% Female	100% Female	76% Male	75% Male

Objectivy & Bias in Clinical Practice: *Creeping Adversarialism*

Martelli, M.F., Zasler, N.D. & LeFever, F. (2000). Preliminary consumer guidelines to choosing a well suited neuropsychologist for assessment and rehabilitation of accuired brain injury. Brain Injury Source, 4, 4, 36-39.

Three shades of Nonobjectivity (Advocacy Bias):

- Plaintiff Advocate;
- Defense Advocate;
- Retaining Side Advocate
- Rampant Bias: *Only in Others*
  - Greater Legal Work Assoc with > Nonobjectivity
  - Bias Type Assoc with Consistent Personality Descriptors
  - Greater Legal Work Not Assoc with Competence.

Diagnostic Realities in Assessment of Impairment and Disability

Real Disorder (e.g., TBI, Pain)		Residual Functional Impairments		Residual Testing Impairments
1. Yes 2. Mixed 3. Indeterminate 4. No		1. Yes & Exaggerated 2. Yes & Not Exaggerated 3. No & Exaggerated 4. No & Not Exaggerated		1. Yes & Not Exaggerated 2. Yes & Exaggerated 3. No & Exaggerated 4. No & Not Exaggerated
4	X	4	X	4 = 64

In progress Study: Appearance of Gross Bias As Reviewed Medicolegal Reports Predominantly Report Black/White Results & Very Infrequently Find Expected Mixtures or Admit Uncertainty

The Federal Judiciary Center Study (2000)

Johnson, M.T., Krafka, C. and Cecil, J.S. Expert testimony in federal civil trials: a preliminary analysis. Federal Judicial Center, 2000.

- Surveyed All Federal Judges, Attorneys from Docket Cases
  - 5 point Likert
    - *1=Completely Objective to 5 = Completely Biased*
  - High Return Rates
    - Average Ratings of Experts: approximately 3.85
    - Similar Results in 1990 and 2000 Studies

Compensation Seeking Status & Examiner Bias (Cont)

- *McBeath, 2000*
  - Examiner response bias in doubting sincerity or veracity of complaints
- *Chapman & Einstein, 2000*
  - Biases in the face of uncertainty in medical decision-making
- *Eylon et al, 2000*
  - Bias in arbitrators' case perceptions and award recommendations
- *Sayer & Thuras, 2002*
  - More negative clinician view of PTSD comp seekers vs non comp seekers

Compensation, Injury and Adversarialism

Longitudinal study of PI MVA litigants *(Evans, 1994)*

- Strongest predictors of successful outcome were
  - Inclusion of psychological services in the Tx plan
  - Receipt of immediate intervention, with return to work (RTW) treatment focus
  - RTW at reduced status or modified duties
- >= 6 months: uncooperativeness and delayed bill paying of medical insurance carriers (vs. medical symptoms) was most frequently reported stressor.
- Insurance carrier bill payment very strongly predicted RTW
  - Prompt (<=30 days): 97% had returned to work.
  - Delayed (> 90 days): 4% had returned to work.

Compensation, Injury & Adversarialism (cont)

Incidence & claim closure speed of Whiplash injury after change to no-fault in Saskatchawan, CA *(Cassidy, et al, 2000)*

- Claims dropped by 28%
- Time to claim settlement was cut by 54%.
- Intensity of neck pain, level of physical functioning, depressive symptoms, having attorney increased claim closure for both
- Their Conclusion: Compensation for pain and suffering increases frequency, duration of claims and delays recovery
- Note: No-fault system eliminated most court actions, income replacement and medical benefits were increased and medical care became universal, without barriers
  - Pre-injury anxiety was associated with delayed claim closure only under the tort system
- More Valid Conclusion: removal of financial disincentives and medicolegal associated treatment barriers and anxiety provocation has a facilitative effect on post-injury recovery.

Case Examples: Harm from Nonobjectivity

Case 1-3, 4-5, 6, 7-9, 10

Publication in process

Conclusions

- Overwhelming prepondenrance of Black/White, dichotomous findings; misrepresent expected natural variability, true uncertainty; "Creeping Adversarialism?"
  - Typicaly Strong Expression of Opposite Opinions in Less than Certain cases
- Numerous examples of subtle to more significant harm: delayed to denied treatment, symptom exacerbation/ complication, emotional distress, iatrogenic disability
- Examiner mistrust & skepticism, hypervigilance to secondary gain/ neglect of secondary losses, anxiety as primary reinforcement, anachronistric dualism and dichotomous thinking, frequent inadequate assessments, frequently conducted by various disciplined professionals with little to no specific treatment experience or training with particiular disorder or spectrum, illogical rehab recommendations, harmful nontreatment, exacerbation of impairment/ disability & delayed recovery
- Percentage of harm in our cases outnumbers cases of gross exxageration, probable malingering, non-injury causation, etc.
- Evidence from case studies consistent with available data on perceptions of prevalent nonobjectivity, systemic Examiner secondary gain
- Pattern seems to be increasing and parallels growth of restrictive health care & IME industry

Minimum Impact Soft Tissue (<$1000. car damage) Profile

- Claims segmented to "MIST" unit
- Carrier takes very hard line
  - ➡ Limit payment over 1k
  - ➡ Litigate All/Most Cases
  - ➡ Use Biomechanics Experts early
  - ➡ Difficult Settlements & Trial: Discourage plaintiff atty interest
  - ➡ If major injury (e.g., disc) --> low value (courtesy) offers --> Litigate with MIST experts
- Frequent Violations: *Fail to:*
  - ➡ Adopt, implement reasonable standards for prompt claims investigation
  - ➡ Pay claims (without conducting reasonable investigation)
  - ➡ Provide reasonable, prompt explanation for denial of claims or compromise settlement

Specific Impediments to Adaptation that Can Increase Likelihood of Response Bias in Pts *(& NPs???)*

- Anger or Resentment or Perceived Mistreatment (e.g., declining reimbursement from insurance companies; declining salaries, etc.)
- Fear of Failure Or Rejection/ Damaged Goods / Loss of Self-Esteem, Efficacy, Confidence Assoc w Residual Impairments (e.g. declining prestige, status, respect, productivity in changing market)
- Job Dissatisfaction (e.g., fighting for authorization)
- Insufficient Residual Coping Resources / Skills (e.g., for competing for remaining reimbursed work, finding something not in decline)
- Disuse Atrophy
- Fear of Loosing Disability Status, Benefits, Safety Net (Medicolegal = our safety net in restrictive environment where can't get regular funding)
- Perceptions of High Compensability for injury (or highly compensated medicolegal work)
- Discrepancies between Personality / Coping Style Behaviors and Injury Consequences (cf Newly Restrictive Health Env = Injury)
- Fear of Pain, Re-injury/Extension/Exacerbation (Health Reimb. inj extension)

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In 2003, major property/casualty insurers' profits were up 89 percent from 2002. (Judy Greenwald, " likely to remain strong," Business Insurance, Mar. 22, 2004)

- In the first nine months of 2003, the property/casualty industry made $23 billion in profits. That' $12.2 billion more than they made during same period in 2002.
- In the first nine months of 2003, life and health insurer profits jumped 437 percent, " best third-quarter increase in a decade."
- Insurance industry' " on equity in 2004 is likely to soar above double digits for the first time since 1997."

CJD Report: Premium Deceit --the Failure of "Tort Reform" to Cut Insurance Prices

Jury verdicts and lawsuit filings are dropping in the US

- 4/1/04: median jury awards in PI cases "fell significantly," dropping 30% in 2002 to $30,000, from nearly $43,000 in 2001.
- Top 10 jury verdicts dropped to lowest total amount since 1997 & number one verdict was lowest in a decade.
- PI case filings dropped 9% over the latest 10-year period studied.

MEDICAL MALPRACTICE

- 1/1/04: "Jury awards for medical- malpractice cases have remained level in the latest three years for which data are available."
- Medical malpractice case filings per capita have been steady for 10 years, showing a slight overall decrease between 1992 and 2001.

(National Center for State Courts, Examining the Work of State Courts, 2002: A National Perspective from the Court Statistics Project (Brian J. Ostrom et al. eds., 2003).

Center for Justice and Democracy:

- "It may be hard to understand why `tort reform' is even on the national agenda at a time when insurance industry profits are booming, tort filings are declining, only 2 percent of injured people sue for compensation, punitive damages are rarely awarded, liability insurance costs for businesses are minuscule, medical malpractice insurance and claims are both less than 1 percent of all health care costs in America, and premium-gouging underwriting practices of the insurance industry have been widely exposed."

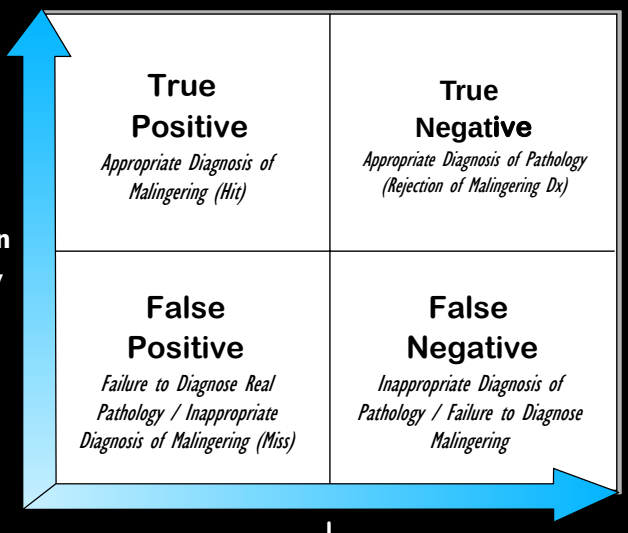
June 21, 2004, Malpractice Myths, By Bob Herbert, NYTimes

SKINNERIAN ASSESSMENT*

- Behavior is Determined by Environmental Reinforcers
- Societal / Cultural Behavior Determined by Collective Environmental Reinforcers
- Whatever Controls Environmental Reinforcers Control Society/ Culture

*Pigeons peck where pellets drop!

Decision Making Theory: Diagnostic Formulation of Malingering



Considerations

- Consequences of False Positive vs. False Negative
- Cost and Availability of Treatment Resources
- Salience, Strength of Reward of Pathology Diagnosis

Compare 1985 (fear of under-diagnosis) and 2002 (fear of over-diagnosis; more restrictive health care system)

INSURANCE PROFIT & WINNING DIAGNOSES

- Malingering --> *No Payment*
- Pre-existing, Little Exacerbation --> *Little Payment*
- Psychological, Non-Organic --> *Small Payment*
- Mostly Psychological --> *Some Payment*
- Mostly Organic --> *More Payment*
- Pure TBI --> Big Payment = Profit Constrainer

INSURANCE PROFIT & WINNING* DIAGNOSES

- . ** Where the Money is...*

Primary Topics Covered In 337 Forensic Conference Presentations

Abstracted in ACN, JCEN, TCN, 1990-2000 (Title & Abstract). *Sweet et al (2002).* The Prominence of Forensic Neuropsychology. TCN, 16, 481-494

Topic	Number of Presentations	% of All Forensic Presentations
Malingering	*242*	*72*
Measures of Cognitive Abilities	14	4
Measures of Personality/Emotion	21	6
Objective	(20)	(95)
Non-specific	(1)	(5)
Projective	-	-
Pathology	13	4
Head/Brain Injury	(7)	(54)

INSURANCE PROFIT & WINNING* Neuropsych Income

- **Or, Where the Money is!*

A. Clinical Treatment Reimbursement, 1990-2000: Sharp Decline
B. Medicolegal Work, IME expenditures, 1990-2000: Sharp Increase
C. The Prominence of Forensic Neuropsychology. *Sweet et al (i2002).*

Year	Topic	# of Forensic NP Presentations	% of All NP Presentations
1990		*12*	*1%*
2000		*46**	*10%*

Year	Topic	# of Forensic NP Articles	% of All NP Articles
1990		*5*	*4%*
2000		*26**	*14%*

86%=Malingering

Binder, Rohling & Larabee (1997) MTBI Metaanalysis

Statistical Justification for Clinicians Rejecting most MTBI diagnoses?

... Just Say No To MTBI?

Pendulum Swing...

Fishbain (2000) Metaanalysis on Waddell signs:

- Not correlated with psychological distress or secondary gain
- Do not discriminate organic from nonorganic problems
- May represent an organic phenomenon
- Associated with greater pain levels and poorer treatment outcomes

Other False Positives Indicators:

➔ Pain Relief by DISTRACTION, FBS, etc.!!!

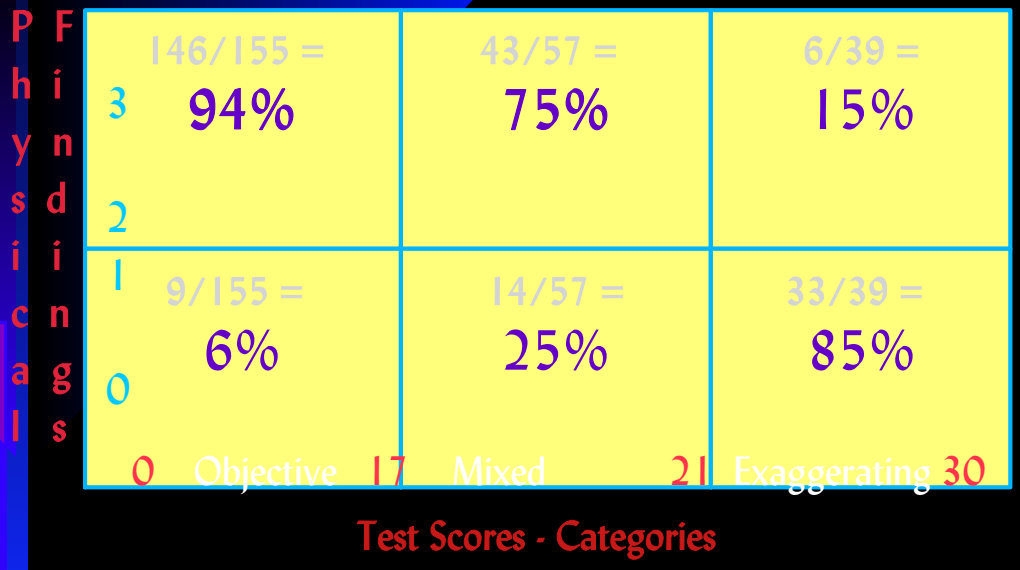
Kinesiophobia*

- Defined as the unreasonable or irrational fear of pain and painful reinjury upon physical movement.
- Phobic responses to pain (or pain phobias), as unhealthy pain maintaining habits, are a major contributor to pain related disability, or Avoidance Conditioned Pain Related Disability (ACPRD).
- After R/O malingering, Combination TX:
  - Reeducation, countering maladaptive phobic responses and promoting adaptive attitudes and treatment participation/ cooperation

**cf Cogniphobia*

Mensana Clinic Test Discrimination Success: "Organic" versus "Functional" Back Pain

($X^2 = 133$: $p<0.0001$)



PRACTITIONER'S CORNER

Feigning /= Malingering: A Case Study

Gregory DeClue, Ph.D.

Researchers and scholars assert that feigning should not be equated with malingering. Some practicing clinicians doing the everyday work of forensic assessment may view this as merely an academic distinction. *This case study illustrates that a high level of certainty about feigning must not be considered indicative of malingering. The case also contrasts two models for assessing malingering and highlights the need for forensic examiners to present assessment-of-malingering data clearly and cautiously.*

SOME MYTHS OF RESPONSE BIAS DETECTION

- It is EITHER/OR (Present/Not; Malingering/Not)
- Clinicians Can Reliably Assess IT
- Symptom Validity Tests (SVT) Measure IT
- SVT's are Valid and Predict Real Test Performance (extended myth: Tests Predict Real Life)
- Patients Take our Exams Seriously
- Customary, Psych/Neuropsych/Medical Testing is Adequate For Assessing IT

Problems with Symptom Validity Measures *(cont)*

- Spector et al., 1999 Compared Performances Across Four Performance Pattern Indices (WAIS-R DS-Vocab; WMS-R Att - Mem; CVLT Recog-FreeRecal; SeashoreRhythmErr's) for:
  - N=136 Mod - Severe TBI
    - 31% Failed 1 Measure
    - 8% Failed 2 Measures
    - 0% Failed 3 or 4
  - N=105 "presumptive malingerers" in compensation seeking group
    - 83% Failed 3 or 4
    - 100% Failed 2 or More

Have we found The Solution??? see next page!!!

Problems with Symptom Validity Measures *(cont)*

- Curtiss, Vanderploeg & Vipperman (1999; 2002) for N=244 Compared 8 Performance Pattern Indices to Report Baserates of Malingering in questionable to severe TBI
  - Only 2 of 8 had <= 10% False Positives (WMS-R; WCST)
  - Review (med, chart, obs, etc.) of Index Classifed Malingerers:
    - Minimum 33% False Positive Rate for MTBI
    - nearly 100% FP rate for Mod- Severe TBI
  - Using >1 Index did not alter F P Rates across groups
  - CONCLUSION: Base Rate Findings indicate that "risk of falsely labelling someone as malingering is unacceptably high with all of the neuropsychological test indices, whether used individually, or in combination."

Problems with Symptom Validity Measures *(cont.)*

This summary of shortcomings should Emphasize:

- 1) the Need for caution in interpretation
- 2) the Importance of employing multiple data sources and making thoughtful inferences only after integration of behavioral observations, interview data, tests results, and collateral sources of information
- 3) the Avoidance of strong statements and black/white opinions, and
- 4) the Need for Further *(and better, more self critical)* Research.

Problems with Symptom Validity Measures

- 1) Psychometric Shortcomings / Poor Psychometric Research
  - Test construction issues re: reliability, validity
  - Wide variability in research sample characteristics
  - Internal validity problems
    - High False Positive Rates even with Simulators
    - Confounding of real & exaggerated in "probable" groups
  - Nonadherence to professional standards for educational & psychological tests
- 2) Generalizability Problems
  - From one SVT to other SVTs (noise to noise ratio?)
  - From SVTs to clinical tests in a battery ("" "")
  - From findings on simulated malingerers (i.e., analogue research) to real malingerers - cf. serial killer research;
  - From findings on "probable" groups to real malingerers
  - From SVTs to functional and clinical symptoms, diagnoses

Problems with Symptom Validity Measures *(cont.)*

- 3) Differential subtlety, sensitivity of different measures
- 4) Confounding of exaggeration and real disorder in clinical groups, individuals
- 5) Law of the Instrument operational definitions wherein "malingering" becomes what "malingering" tests measure. (Definitions of "effort"? Construct validity data? Multitrait, multimethod matrices? Uuniformity assumptions across diagnoses, litigation vs not, etc.) Anal-Cephalic Criterion Inversion*... cf Martelli, et al 2001 - 40% malingering rates*
- 6) Unknown, Unstudied, Indadequately Studied Effects of Numerous Relevant Variables:
  - Fatigue, Disinterest, Non-attended administration, Pain
  - Neurobehavioral symptoms: impersistence, adynamia, dysexecutive, depression *(except criterion snatching!)*
  - Adversarial Context

Problems with Symptom Validity Measures *(cont.)*

- 7) High False Positive Rates even with Simulators
- 8) High False Positive Rates in the only Studies of real Clinical Samples (e.g., 2 large samples)
- 9) Use of any current SVT/Index violates 2002 APA ethics and "APA Standards for Ed. & Psych. Tests" with regard to Diagnosis, Decision making
- 10) Use, per APA 2002 Ethics Code:, requires Informing re: Limitations
- 11) BOGUS PIPELINE Problem
  - Examiners
  - Juries (cf VTLA, 2002, polygraph, fingerprints)
  - Creeping Adversarialism, Criterion Snatching & Replacement of Science with 51% Legal Standard

Analysis of a Pellet Pecker*

(List borrowed from Lloyd Cripe, in press; Title adapted from BF Skinner)

- 1. " I don't believe that a human could be significantly injured by a mild head injury and if they are, they should snap-out of it in a few weeks...
- 2. If they don't snap out of it, they are weak manipulative people and whatever problems they continue to have are due to their pre-existing weaknesses or desire to win the lottery.
- 3. Any sign of poor effort means manipulation and malingering.
- 4. If the patient shows poor effort on the one test of effort that I cherish, all the others mean nothing and the patient is most probably consciously malingering.
- 5. If the patient does okay on the effort test(s) and shows any weaknesses (variability) on the neuropsychological tests, it can only be explained by 'other factors' especially 'emotional factors.' ...

Pellet Pecker Tricks *(continued)*

- 6. ...Elevations on the MMPI are dead-ringer signs of "emotional factors."
- 7. If a patient has elevations on the MMPI, that explains everything and instantly negates any other poor test performances even though there is little or no correlation between the MMPI and NP tests.
- 8. What the patient says doesn't matter.
- 9. Self-report is useless, except the self-report on the MMPI, and my self-report!
- 10. Test scores are reality...regardless of Patient presentation and the reality of the patient....

Pellet Pecker Tricks (continued)

- 11. ...Anyone that is involved in medical-legal litigation is either deceiving (patient) or being deceived (plaintiff counsel and experts), except me! I am the only one that can keep my head straight in all of this.
- 12. All the treating persons that have seen this patient know less than I, have been duped and must have scrambled-eggs (or possibly shit) for brains.
- 13. How I behave in an examination has no impact whatsoever upon the patient's behavior. Only they can manipulate the outcome.
- 14. Neuropsychological test data is never wrong and is near rocket-science.
- 15. Record review is never influenced by my biases! ...

Pellet Pecker ... (continued)

- 16. ...What is written in records is solid truth, especially the parts I like and the parts that get my attention.
- 17. If you look long and hard enough, you can always find something in the history that explains away the current complaints of the patient.
- 18. Money is the only thing that matters and motivates people. All humans, except me, are money grubbing greedy bastards and will sell their souls for some bucks!
- 19. Secondary-gain means everything and losses mean nothing!
- 20. The last chapter has been written on mild head injury and I know what it says!"

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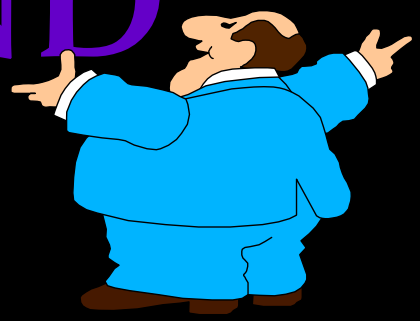

NEXT: Part III

Possible Solutions