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Legal Preparation of a Case of Traumatic Impotence

Recently there was a civil case tried before a jury in the Superior Court of New Jersey of Morris County on behalf of a plaintiff seeking damages for traumatically induced impotence. The issue was one of first impression in the New Jersey courts and raised a number of interesting medicolegal problems. This paper attempts to illustrate them for the forensic psychiatrist, medical expert, and practicing attorney.

Of greatest moment was the problem of a definitive evaluation in a medical area where classification is difficult and where organic, psychologic, and personal gain or compensation factors must be carefully weighed and presented.

Factual Background

The plaintiff, Mr. X, a 49-year-old white male self-employed realtor, fell on a fire escape while showing a commercial building to a prospective purchaser in October, 1973. He dropped through an unguarded opening, sustaining a straddle-type injury to his groin, testicles, and penis. He sustained no severe lacerations but developed ecchymosis on the right side of the penoscrotal junction. In the hospital he was found to have a "tender boggy prostrate." Bleeding from the urethral canal ensued. Severe complaints of pain were registered. A diagnosis of "traumatic epididymitis, prostatitis, with a possible urethral stricture" was made. Discharge from the hospital occurred within two days, following which attendant care by urologists and internists ensued. A series of cytoscope examinations and retrograde pyelograms were completed and all results were found to be "within normal limits." Pain continued in the area of the perineum for several weeks. No surgical procedures occurred. Bleeding from the urinary tract was intermittent and subsided in approximately 2½ months. The patient developed a high degree of anxiety over his physical discomfort and injuries. Sexual relations were attempted by plaintiff with his wife (a woman in her early forties and in good health) approximately three months after the trauma. These proved unsuccessful because of pain and incomplete intromission. Coital relations were delayed for several more weeks, but subsequent attempts to resume them were unsuccessful. The plaintiff's wife exhibited patience and understanding in the face of this difficulty. The previous sexual history of the parties was reported as "normal." Five children had been born of their marriage. No previous complaints of impotence or sexual incapacity predated the incident. However, the complaints of plaintiff's impotence worsened and stabilized so that at the time of trial, 2½ years later, the plaintiff's impotence persisted.

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Problems Encountered in Diagnosing the Injury

The trial lawyer's constant objective is to be thorough and complete in preparing evidence for trial, particularly medical evidence. Before this could be done in the present case the plaintiff's condition had to be accurately diagnosed. One problem was caused by the limitations in knowledge generally demonstrated by the medical doctors who consulted with plaintiff about his impotence, and specifically, its genesis, the compound nature of the impotence, and the problems in diagnosing and treating it. One of the initial treating physicians, a urologist, could not reconcile the plaintiff's complaints of pain with increasing evidence of organic normality based on the tests and observations and thus he spoke of "marked psychogenic overlay." A prominent neurologist, to whom the plaintiff was referred for an examination a year after the trauma, considered venography to determine if the erectile process had been damaged organically. He also expressed interest in hormone testing to determine if the plaintiff's testosterone level was markedly reduced. However, he found no initial evidence of organic impotence based on discernible neurologic injury. The plaintiff was referred to two additional urologists, and one conducted a blood testosterone level test one year and five months after the trauma; results were normal. In the course of time prostatic and urinalysis testing continued to provide normal results. However, continued complaints of inability to obtain an erection and experience orgasm persisted one year and six months after trauma. Because the plaintiff's complaints were being litigated, the defense adopted a posture of skepticism regarding the authenticity of his impotency—not an unreasonable attitude in view of the difficulties in measuring such deficit.

Ultimately, the plaintiff was referred to the Institute of Mental Health Services, Department of Psychiatry, Rutgers Medical School, College of Medicine and Dentistry in Piscataway. A 5-h interview ensued with Irwin Perr, M.D., of the school faculty, and a comprehensive review of all medical records, hospital records, and physicians' reports was completed. Traumatic organic impotence of a temporary (and possibly permanent) duration was considered as the most likely diagnosis, followed by a severe neurotic reaction characterized by anxiety and depression 19 months after the trauma. To put it differently, it was felt that organicity could not be sufficiently excluded on the basis of the prior evaluative workups.

Achieving the Diagnosis

Personality testing of the plaintiff by Dr. Perr revealed depression, anxiety, an intense need to appear in harmony with others, and marked evidence of pessimism and worry. The MMPI (Minnesota Multiphasic Personality Inventory) was compatible with the clinical history and revealed the use of neurotic defenses to control anxiety. The clinical evidence did not rule out overt organic damage. However, a newer method of achieving a more positive diagnosis of organic impotence was suggested in the form of sleep testing and the use of penile mercury strain gage apparatus. The plaintiff was referred to Dr. Charles Fisher, M.D., Ph.D. [*1,2*], at Mount Sinai School of Medicine, City University, New York.

The plaintiff was fully informed of the purpose of the sleep tests and, after much resistance, consented to them. Four sleep tests employing the use of an electroencephalogram and a penile mercury strain gage were conducted on the plaintiff on 15, 18, and 22 Dec. 1975 and on 5 Jan. 1976, at Mount Sinai Hospital in New York. It was determined that the plaintiff had erectile capacity during sleep but that these did not coincide with normal patterns of REM (rapid eye movement) sleep. He awoke in pain and discomfort following the onset of tumescence or erectile activity during sleep, which underscored the deep-seated nature of his psychogenic impediment. It was further concluded from the tests that plaintiff has psychogenic impotence to an extreme degree, and was "as disabled as he could be if he had a severe organic condition."

Evidentiary Problems with the Medical Evidence

Strenuous objections by defense counsel to the introduction of the results of the Mount Sinai sleep tests were anticipated. Dr. Perr and his colleague, Dr. Raymond Rosen of the Psychiatric Staff at Rutgers Medical School, relied on the results of the sleep tests, which were recorded on graph paper by a sleep technician who monitored the apparatus during the sleep tests. The deposition of this technician was taken, and his identification of the graph paper which comprised the recordings and tracings of the REM and non-REM periods of sleep by the plaintiff was made a matter of record. This was a critical step in the pretrial discovery process. Dr. Fisher was unavailable to testify. However, Dr. Rosen, the director of a sex research laboratory, was available and willing to testify as to his use of the sleep testing apparatus and the function of the penile mercury strain gage which he used at Rutgers. At trial, and over objection, the reading of the sleep technician's deposition testimony was allowed. Next the summarized tracings and erectile data achieved during the four nights of sleep testing were identified as trial exhibits. The testimony of Dr. Rosen, who was well acquainted with sleep testing apparatus, was allowed before the jury. Finally, the results of the sleep tests, and the medical opinion of Dr. Rosen as to their significance, were also permitted to be introduced as evidence. The jury came to a fuller and more complete understanding of the true nature of the plaintiff's problem. He was awarded $100 000 with a reduction of $25 000 for contributory negligence. His wife recovered a verdict of $25 000.

Role of the Forensic Scientist

The written material dealing with the courtroom presentation of medical evidence by experts is practically inexhaustible [*3–12*]. Much of it deals with the specifics of presenting scientific data in court, but certain general precepts should be repeated. While a trial is essentially a combative exercise, with lawyer-adversaries confronting each other, the forensic medical witness need not feel uncomfortable nor ill at ease in performing his or her function. The key element is to be informative. The jury is there to learn. Most jurors appreciate the learning process. However, scrupulous adherence to the truth and intellectual candor must be the polestars of the forensic scientist. The witness should be relaxed, good-natured, and thoroughly conversant with the subject matter, but should not be flippant nor appear overly ingratiating nor jocular. A calm, steady demeanor with an attentive ear for all questions should be adopted. Long, tedious, and overly technical discourses should be avoided. The attorney doing the questioning should not have to appear as one who interrupts his witness, a possibility when the scientific witness rambles or elaborates in excess detail. Jurors tire of long, amplified answers filled with technical jargon; they like simple, direct answers, spiced occasionally with illustrations of human experiences they can relate to. A sense of humor also helps. In dealing with sexual matters, the scientific witness need make no apologies for what might be a sensitive area for discussion in another forum. Most jurors are aware of, sympathetic to, and interested in various sexual dysfunctions. They may, however, lack complete and accurate knowledge of the subject. It is the trial lawyer's function to use the forensic scientist as a teacher and educator. Together, the lawyer and his scientific witness can illuminate some of the misconceptions and uncertainty that affect some lay jurors and open their minds in their search for the truth. The trial court will also be helped and guided to a fuller understanding of the scientific or medical issues in the case.

Finally, cross-examination should not be feared, but should be welcomed as a clear opportunity to the forensic witness to defend his thesis. It is here, under the often relentless questioning of the opposition, that the true worth and substance of the forensic witness's testimony will shine forth. Here is where the truth will be sharply honed and the jury persuaded to the scientific essence of the case.

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