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SECTION 11

BRINGING INVISIBLE INJURIES TO LIFE

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MILD TRAUMATIC BRAIN INJURY: RECOGNIZING THE SYMPTOMS, DIAGNOSING AND TREATING THE INJURY

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"MILD TRAUMATIC BRAIN INJURY: RECOGNIZING THE SYMPTOMS, DIAGNOSING AND TREATING THE INJURY"

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By

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1. Definition of Traumatic Brain Injury:

Traumatic Brain Injury (**TBI**) is an alteration in brain function or other evidence of brain pathology caused by an external force.[1] Injury to the head arises from blunt or penetrating trauma or from acceleration/deceleration forces. Such an injury is associated with one or more of the following:

- Decreased level of consciousness;
- Amnesia;
- Neurological Abnormality;
- Neuropsychological Abnormality;
- Skull fractures; or
- Intracranial lesions.

2. Causes and Mechanism of Injury:

The major causes of TBIs include falls (35%), motor vehicle collisions (17%), struck by/against events (16%), assaults (10%) and other/unknown (21%).

The mechanism of injury ("MOI") is the process that produced the injury. The most common MOIs are:

- blunt force trauma;
- penetrating injuries;
- acceleration/deceleration forces; and
- abusive head trauma ("AHT").

Acceleration /deceleration force exposures are associated with diffuse axonal type injuries, while penetrating injuries are localized to a certain location of the brain tissue.

Regardless of the underlying MOI, brain tissue becomes distorted or deformed in the process of TBI. Medical studies indicate that lesser degrees of injury may still occur even if brain tissue stays within its elastic zone and returns to its original shape. The momentary deformation is enough to produce a TBI.

[1] Menon DK, Schwals K., Wright DW, "Position Statement: Definition of TBI," Archives – Physical Medicine & Rehabilitation, Nov. 2010

3. TBI Injury Severity Classification:

TBIs are classified into three categories: mild, moderate and severe. The Glasgow Coma Scale (**GCS**) is the most widely used scale to determine the injury severity at the acute stage. It should be noted that the GCS score could be compromised by acute interventions such as intubation, medications or intoxication. Some experts have suggested that loss of consciousness and post-traumatic amnesia are better predictors of functional status. As defined by GCS, the TBI falls into the following three (3) categories:

- Mild → GCS 13 -15
- Moderate → GCS 9 – 12
- Severe → 8 or less

There are other measures to assess TBI severity, including structural imaging findings, duration of loss of consciousness, altered consciousness and/or post-traumatic amnesia; GCS scores; and the Abbreviated Injury Severity Score.

The following table sets forth the criteria used to classify TBI severity:

CRITERIA USED TO CLASSIFY TBI SEVERITY

	TBI Severity		
Criteria	**Mild**	**Moderate**	**Severe**
Structural imaging	Normal	Normal or abnormal	Normal or abnormal
Loss of consciousness	<30 minutes	30 minutes to 24 hours	>24 hours
Posttraumatic amnesia	0-1 day	>1 and <7 days	≥7 days
Glasgow Coma Scale score[a]	13 – 15	9 – 12	3 – 8
Abbreviated Injury Scale score: Head	1 – 2	3	4 – 6

[a]Best available score in 24 hours.

Source. Brasure et al. 2012; adapted from Centers for Disease Control and Prevention 2015.

4. **Mortality Rates**:

One study followed adolescents and adults receiving inpatient rehabilitation for a primary diagnosis of TBI in the U.S. from 2001 – 2010. Life expectancy was shortened between 1 and 10 years, depending on age at injury, race and sex. On average, TBI reduced life expectancy by 9 years.[2]

5. **Diagnosis of the Mild TBI**:

After initial assessment and stabilization, radiographic studies are ordered. CT scanning tends to be a vital tool in the emergency room. CT scans are excellent tools for detection of hematomas, hemorrhagic lesions and contusions. Obviously, x-rays easily identify any skull fractures. Magnetic Resonance Imaging (MRI) has become the more prevalent tool in diagnosing TBI.

With or without radiographic evaluation, the neuropsychological assessment is essential. Neuropsychological exams may be considered an extension of the mental status examination, but they are more comprehensive and detailed in their coverage of higher level, complex brain function.

With any head injury, the primary focus in the emergency room setting is the need to rule out surgical intervention due to brain bleeds, swelling and other life-threatening conditions. After stabilization and consult with neurosurgery, the plan would be to observe the symptoms over time.

6. **The Mild TBI**:

The pathology and pathophysiology of a mild TBI are poorly understood. Despite the fact that mild TBIs rarely develop significant complications, some patients will deteriorate over time.

Many mild TBI patients complain of headaches, dizziness, vertigo, irritability, inability to concentrate, impaired memory and fatigue. Very few patients having these symptoms exhibit objective focal neurological deficits. Nevertheless, these symptoms impact their lives.

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[2] Harrison – Felix C, Pretz C et al., "Life Expectancy After In-Patient Rehabilitation for Traumatic Brain Injury," Journal of Neurotrauma 2015.

7. Neuropsychological Assessment:

Neuropsychiatric assessment is vital to the treatment of the cognitive problems experienced by individuals with a mild TBI. The cognitive domains that are typically affected by a TBI include:

- Attention;
- Processing speed;
- Memory;
- Functional Communication; and
- Executive function.

There are a battery of psychometric tests to help assess the loss of cognitive function.

The assessment has several goals, including:

1. Identifying residual cognitive impairment, psychological issues;
2. Fine-tuning of treatment plans; and
3. Recommendations for future care.

Issues that are to be addressed during assessment and treatment include:

- Need for and level of supervision;
- Potential need for additional services; and
- Restrictions or accommodations regarding school, work, driving, and other ADLs.

The neuropsychological assessment will pinpoint the areas of cognitive deficits, the severity, and will provide the roadmap for treatment modalities.

8. Proving the Mild TBI at Trial:

The lack of dramatic radiographic images, hospitalizations and dramatic personality changes makes the case of a mild TBI very challenging. Those suffering the effects of a mild TBI "walk and talk" like the normal person; hence, the term the "invisible injured." Oftentimes the best evidence is the testimony of family members and others who testify to functioning levels both pre-incident and post-incident.

Co-worker testimony can document changes to productivity due to lingering symptoms associated with a mild TBI. A teacher/professor can provide testimony regarding

changes in grades and processing speeds. Family members can discuss personality changes, fatigue, confusion and other changes. It is therefore vital that an aggressive interview protocol be followed.

Visual evidence in proving the mild TBI and its long-term effects can't be discounted. A simple animation or graphic showing of the brain's movement within the skull gives the jurors an "insiders" view of the trauma. Photos of any head swelling, bruising or lacerations are paramount. Give the jurors something to see!

INVISIBLE INJURIES: THE EGGSHELL PLAINTIFF

By Lauri Brenner

Defendants will focus on a pre-existing condition or injury to eliminate responsibility or reduce the amount of compensation a plaintiff should receive. Luckily, the law in California affords plaintiffs the right of recovery of damages when plaintiff can show 1) a pre-existing condition was aggravated or made worse by defendant's conduct, and/or 2) plaintiff's pre-existing condition made her more susceptible to an injury. This is known as the "eggshell plaintiff" rule requiring that a *defendant must take the plaintiff as they find them.*

CASE LAW

- *Sanchez v. Kern Emergency Medical Transportation Corp.* (2017) 8 Cal.App.5th 146;
- *Ng v. Hudson* (1977) 75 Cal.App.3d 250;
- *Rideau v. Los Angeles Transit Lines* (1954) 124 Cal.App.2d 466, 471.

APPLICABLE JURY INSTRUCTIONS

- **CACI 3927.** Aggravation of Preexisting Condition or Disability

  Plaintiff is not entitled to damages for any physical or emotional condition she had before Defendant's conduct occurred. However, if the plaintiff had a physical or emotional condition that was made worse by Defendant's wrongful conduct, you must award damages that will reasonably and fairly compensate her for the effect on that condition.

- **CACI 3928**. Unusually Susceptible Plaintiff

  You must decide the full amount of money that will reasonably and fairly compensate plaintiff for all damages caused by the wrongful conduct of defendant even if plaintiff was more susceptible to injury that a normally healthy person would have been, and even if a normally healthy person would not have suffered similar injury.

TRIAL STRATEGY

Voir Dire

It's vital to plaintiff's case to voir dire on the issue(s) of "aggravation"/"made worse" and "more susceptible." Use an honest approach based on reasonableness, fairness and one supported by the above law. Do not avoid the topic and allow defense counsel to control the narrative during jury selection and in opening statement. Failure to address your client's pre-existing condition or susceptibility during jury selection or opening will cause the jury to distrust you and view your client as a person attempting to profit off defendant for an old injury defendant did not cause.

- Who here has suffered an injury or has a physical or mental condition that may even still cause pain, discomfort or some suffering? Tell me about that.

- Let's say an old injury or condition was made worse by someone else's negligent conduct, does anyone here think that it's unfortunate, but it's not the other person's fault because this person already had an injury to that same area of the body? Some people may feel it's too bad that you are "damaged goods" but it's not fair to make someone else responsible for your already existing injury or condition even if that person's conduct made you feel worse; and then there are other

people who feel that if a person's negligent conduct makes worse someone's pre-existing condition, then that person should be held responsible for the extent of the injury made worse by the negligent conduct.
Which group of people do you agree with? Tell me why you feel that way.

- Do you think some people are more susceptible to injuries than others? If a person is more susceptible to an injury due to age or a prior medical condition, some people feel that a defendant who causes injury to such a person should not be held responsible for causing injuries because that person was more likely to be injured (injury prone) and that's not fair to a defendant; then there are other people who believe that it is fair because you have to take your plaintiff as you find her. A person who causes injury should be held responsible for the extent of the injury caused regardless if that injured person was more susceptible to an injury.
  Which group of people do you agree with more? Tell me why you feel that way.

Plaintiff's Treaters and Experts @ Trial

Use plaintiff's treater or experts before and after accident to compare and contrast plaintiff's pre-existing condition from current injury.

- Pain prior to accident was 2/10 vs. 6/10-10/10 since accident;
- Plaintiff treated conservatively with PT or Chiro treatment before accident vs. epidural injections and surgery required after the accident which was not recommended prior to accident;
- Elicit through expert or treater that plaintiff was not under the care of medical provider at time of accident vs. since the accident plaintiff has been to doctor, i.e. 20 times, including emergency room on date of incident;
- Establish a timeline to help jury visualize the stark contrast of treatment prior to accident vs. after accident.

Use treater and/or experts to diagnose plaintiff's condition as a "chronic pain" condition caused by the accident that did not exist before the accident:

- Chronic pain is pain that persists for more than 3 months;
- Chronic pain means conventional treatment has not resolved plaintiff's pain vs. plaintiff's pain either resolved or was significantly less before accident.

Use treater and/or experts to describe the effect of chronic pain on patients:

- Restrictions on Daily Activities of Living since accident vs. before;
- Anxiety/stress/grief since accident vs. before accident;
- Loss of income since accident vs. before accident;
- Plaintiff requires pain meds since accident vs. before accident;
- Sleep disruption since accident vs. before accident;
- Psychological/emotional impact since accident vs. before accident

Use treater and/or experts to explain the natural degenerative and aging process to explain that plaintiff's pre-existing condition is expected, common and, most importantly, was *asymptomatic* prior to the accident. The forces applied to plaintiff's degenerating spine caused plaintiff to become symptomatic.

Defense Experts @ Trial

Use the defense experts to get concessions and prove your case:

- Elicit no evidence of malignering/exaggeration during DME;

- Elicit positive exam findings during DME compared to medical records prior to accident;
- Elicit favorable facts from medical records from before vs. after accident to prove condition made worse, i.e. plaintiff discharged from PT 1 year before accident; the highest level of pain reported by plaintiff before accident was 3/10 vs. 8/10 after accident; no treatment provider ever recommended injections or surgery prior to accident vs. after the accident recommendation; disc bulge before accident was 1 mm vs. 4 mm after accident, etc.
- Elicit the number of appointments in 2 years before accident vs. the number of appointments after accident.
- After establishing the above differences, ask the defense expert, given everything we have just discussed and the differences between plaintiff's condition before the accident vs. after, you agree plaintiff's condition after the accident was made worse?

    - If the defense expert dares to disagree, then begin to impeach with questions related to the expert's *BIAS*, i.e., retained by defendants in 90% of cases, earns $750k/year for expert work, etc.

Call Plaintiff's Spouse, Kids, Parents, Co-workers, & Friends @ Trial

In addition to plaintiff's testimony, call others close to plaintiff to give credibility to the extent of the injuries caused by the accident and highlight how the injuries have effected plaintiff's lifestyle and emotional state.

- A spouse, parent, child, etc. can testify to real life examples of what the plaintiff could do before the accident vs. after the accident; and describe plaintiff's pain and suffering through a different lens. This will increase value in the case while further corroborating causation.
- Use photographs and videos of plaintiff before the accident showing him/her doing activities that he/she can no longer do (hiking, running, volunteering, traveling, cooking). Contrast those images with photos of videos of plaintiff in the hospital, using a walker, doing PT; or show a photo of the safety handles that had to be installed in plaintiff's shower; or have plaintiff demonstrate how she uses a tens unit every day. Images are powerful and make jurors *feel* the extent of the loss.

CLOSING

The eggshell plaintiff doctrine is premised on fairness to ensure full, reasonable and fair compensation. Use CACI 3927 and 3928 to highlight defendant's "tactic" or "strategy" in trying to use plaintiff's prior condition as a means to save money and avoid taking responsibility, contrary to what the law requires the jury to do. A plaintiff's pain and suffering is the ultimate *invisible injury* and it is also the greatest damage in your case. Use **CACI 3905A** and argue all applicable non-economic damages, i.e pain and suffering, loss of enjoyment of life, inconvenience, grief, anxiety, emotional distress, physical impairment. Each item is a separate damage requiring compensation. Support your argument with the testimony you elicited and the images you showed the jury illustrating the profound loss to your client.

COMPLEX REGIONAL PAIN SYNDROME

By Christopher Dolan

1) CPRS An Overview
   Definition
   CRPS I v CRPS II
   Characteristics
   Neurologic Pathways

2) Distribution Among Sub-Groups
   Male Female
   Upper v Lower Extremities
   Frequency Among Age Groups

3) CRPS II
   Cause and Origin
   Identification/Diagnosis
   Appearance
   Clinical and Objective Presentation
   Developing Diagnostic Tools – Imaging

4) Factors Impacting Intensity
   Stress
   Sleep Disruption
   Depression
   Disability

5) Treatment Methods
   Mobilization
   NSAID's, Neuropathy, Gabapentin, Nortriptyline
   Surgical Intervention
   Opioids
   Ketamine

6) Psychological Complications
   Anxiety, Depression
   Sleep Disorders
   Suicidality

7) Case Study

PROVING EMOTIONAL DISTRESS IN THE ABSENCE OF ECONOMIC INJURIES

By Geoffrey S. Wells

I. What are invisible injuries and how do we make them come to life?

A. CACI 3900

The amount of damages "must" include an award for "each" item of harm that was caused by defendant's wrongful conduct, "even if" the particular harm could not have been anticipated.

Plaintiff does not have to prove the exact amount of damages that will provide reasonable compensation for the harm. However, you should not speculate or guess in awarding damages.

B. CACI 3905A

Plaintiff's past and future physical pain, mental suffering, loss of enjoyment of life, disfigurement, physical impairment, inconvenience, grief, anxiety, humiliation, emotional distress. This instruction allows you to add in other damages such as:

-- Loss of love

-- Loss of companionship

-- Loss of emotional support

Reasonable amount based upon the evidence and your common sense.

C. Testimony from client, family and friends

-- Letters, pictures, videos, photos of trips, life events, sports, hobbies, charities

-- Emotional distress: Physical manifestations, social interactions, family, spouse, friends, church, book clubs, etc.

D. Think about human damages

-- Harms, past and future

-- Eliciting witness testimony through visual aids

E. Reminder that general damages for past and future are never reduced to present cash value (CACI 3905A, which states as follows:

"For future [insert item of pain and suffering], determine the amount in current dollars paid at the time of judgment that will compensate [name of plaintiff] for future [insert item of pain and suffering]. [This amount of noneconomic damages should not be further reduced to present cash value because that reduction should only be performed with respect to economic damages.]]

MILD TRAUMATIC BRAIN INJURY
BIOMECHANICAL ISSUES, PROVING THE CASE

By Gary A. Dordick

INTRODUCTION

The key to establishing mild traumatic brain injury is to analyze the accident events, beginning with an understanding of your client's movements as a result of the accident to determine what forces were exerted on their body. Once you know the mechanics of what occurred, you can evaluate the likelihood of those forces causing injury to the brain. Be aware that your client's recollection of the accident details may not be accurate. Traumatic brain injury can affect the plaintiff's recall of the important information that leads to a diagnosis of the condition. Often, third-party witness accounts of their observations of the plaintiff at the scene of the accident are more probative.

Look at first responders' reports for any sign of head injury. However, subtle signs of head injury are often missed in the field. Mild traumatic brain injury can be caused from the client's head striking the head rest, which may leave no sign of injury on observation by medical staff. Without obvious signs of head trauma there may be no mention of concussion or head injury in the medical records, even in cases of significant mild traumatic brain injury. The lack of documentation may make the injury harder to prove, but it does not in any way mean that a mild traumatic brain injury does not exist. Most first responders and emergency facilities are looking for life-threatening conditions and are not looking for subtle changes in cognition that are present in mild traumatic brain injury cases. Emergency room personnel are looking for brain hemorrhages and other acute conditions requiring emergency care. Emergency personnel do not have any familiarity with your clients prior to encountering your client in the field or in the ER and are not equipped to determine subtle changes in cognition. Field work is generally limited to a Glasgow Coma Scale assessment, which almost always produces a normal score of 15. A normal Glasgow Coma Scale does not rule out mild traumatic brain injury.

You want to scan all of the records, including the traffic collision report, first responder's notes and reports, and emergency room records to determine if there is any evidence of impact with your client's head. More subtle impact marks are often missed unless they result in the need for sutures. Padded and cushioned portions of the interior of a vehicle can result in mild traumatic brain injury, as can the deployment of an air bag. Part of the difficulty with diagnosing mild traumatic brain injury is there may be no physical signs of injury, but the brain has significant trauma internally that is not shown on MRI or CT scans.

In the emergency room, if they suspect a possible head injury, they may order a basic MRI or CT scan. However, normal MRI's and CT scans are present in the vast majority of mild traumatic brain injuries.

PROVING MILD TRAUMATIC BRAIN INJURY

Some of your most important sources of information are family and friends who have had the opportunity to observe the plaintiff before and after the accident. Family and friends will notice subtle changes that emergency personnel cannot appreciate. Interviewing family and friends is critical, and knowing the right questions to ask is essential. Obviously, people have different levels of attention to subtle changes in personality. By asking questions that draw out information commonly associated with traumatic brain

injuries, you may flush out a valid injury when family members were not aware of the condition or the severity of the condition.

Mild traumatic brain injury results in limitations significantly beyond simple issues of short-term memory. Mood and personality changes are frequently associated with frontal lobe injuries caused by mild traumatic brain injury.

When interviewing your clients, their families, and their friends, ask questions about the client's sensitivity to light, sensitivity to noise, difficulty with large crowds or busy environments. Ask about increased irritability, anxiety, and sleep disturbance. Discuss difficulties finding words when making sentences. Discuss real-life examples of short-term memory loss like forgetting why they went into a room in the house, or why they picked up their keys, forgetting the toaster oven is on, the iron is hot, etc. Ask about headaches or ringing in the ears, difficulty reading or paying attention in conversation, difficulty making decisions or planning out the sequence of events, like when making a meal. Ask about lack of sex drive, a preference to be alone rather than with family or friends. Inquire about physical changes like whether there are any changes in vision, taste, smell, or balance. Ask about any difficulty with their hearing since the accident. Discuss any instances of inappropriate behavior that might have been awkward or embarrassing. Temper control is often an issue, as is disinhibition. Read a neuropsychologist's report on the client. Look at the subjects covered and the nature of the doctor's comments and discussion. Your questioning must be in the same areas, looking for the same type of information. You are prescreening for neuropsychological deficits.

BASIC MEDICINE AND CONCEPTS

A traumatic brain injury can occur from direct blows and severe acceleration-declaration forces. Coup-contrecoup reflects two different injury sites, one from a blow and one caused by the brain bouncing back and forth against the skull. This type of injury can be associated with a rear-end type collision or a frontal impact collision and often is associated in clients that have falls. The brain is soft and surrounded by the hard skull. When the brain is rapidly accelerated and decelerated, the brain will impact the skull causing coup-contrecoup injuries.

After some type of head trauma or coup-contrecoup acceleration/deceleration event, the biomechanical and physiological events that occur can include a breakage of the neuronal membrane, decrease in cerebral blood flow to the neurons, increased demands for glucose (which is not present in sufficient demands to maintain a deficient blood supply, and combined with deficient oxygen supply, can lead to a metabolic disturbance) an immediate release of excitatory neurotransmitters causing neurons to fire repeatedly until they die. It is the cumulation of these events that lead to traumatic brain injury. It's complicated, but understand the changes are not structural and can not be seen on standard imaging tests.

Often the injury in mild traumatic brain cases is to the frontal lobe and temporal lobe portions of the brain. The frontal lobe involves attention, emotion, social and sexual control, decision-making, expressive language, motivation, judgment, spontaneity, problem-solving, motor integration, voluntary movement, and sequencing. Analyzing the list of frontal lobe controls, you can see how difficult it can be to prove deficits in these areas as they are often very subjective aspects of a person's life and it is difficult to determine pre-morbid or pre-accident functions in these particular areas. For this reason, one of the most important aspects of proving a mild traumatic brain injury case involving the frontal lobe is through third-

party non-medical witnesses. It is essential to have as many friends, coworkers, next-door neighbors, business associates, religious leaders, and family testify to the changes in the plaintiff before and after the collision.

Temporal lobe controls involve short-term memory, receptive language, language comprehension, selective attention, object organization, and behavior-aggressive tendencies. Deficits in this area are frequently only demonstrated after a battery of neuropsychological testing.

Other important complaints frequently associated with mild traumatic brain injury include dizziness, poor balance, nausea, fatigue, ringing in the ears, headaches, motion sickness, sensitivity to touch, depression, anxiety, irritability, sleep disturbance, disorientation, and confusion. Again, the people around the plaintiff are the best ones to assess deficits in these areas and because the plaintiff will often not be a very good historian as to their own limitations.

BE AWARE OF THE TRAPS

Part of the difficulty with mild traumatic brain injury cases is that the nature of the injury often prevents the plaintiff from making the best-decisions, relative to their own well-being. In addition to problems with decision making M-TBI can also result in the plaintiff not being aware of their own deficits. Having a plaintiff testify in deposition or trial to their limitations in severe cases can be ineffective other than for the benefit of showing that the plaintiff may be completely unaware of their own limitations. The defense will often point out that the mild traumatic brain injury victim has not sought out appropriate care for their condition. The plaintiff must have the experts explain how the failure to seek proper care is part of the very nature of the injury and why there should be funds provided in the life care plan for a medical manager to assist the plaintiff with obtaining necessary care and actually attending necessary appointments.

It is critical to understand that in mild traumatic brain injury cases, the MRI scans and CT scans are almost always normal. Do not fall victim to the defense trap that there is no brain injury because the emergency CT scan or MRI scan was interpreted as normal. By definition, the CT scan and MRI scan are normal in a mild traumatic brain injury. If the scans show evidence of subdural hematomas, skull fractures, and structural changes, you are almost always in the realm of a moderate traumatic brain injury which has entirely different diagnostic criteria.

CONCLUSION

Analyze your client's case from the second of impact. Look for any forces that could cause damage to the brain on a molecular level, not structural.

Make sure you know the medicine surrounding your client's injury when you are presenting the case. You need to know what to look for in your client to assist your client with the appropriate diagnoses for treatment purposes and for presentation of evidence throughout the case and at trial. Opposing experts often cancel each other so your cases will be won with family, friends, co-workers, and the like.