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TRAUMATIC BRAIN INJURY TWO VIEWS FROM NOTED ATTORNEYS

VOCATIONAL ECONOMICS, INC.

This issue reflects two points of view from noted trial attorneys: Charles N. Simkins, Esq., Simkins & Simkins, Northville, Michigan David F. Wentzel, Esq., McDermott, Will & Emery, Chicago, Illinois

Mr. Simkins:

Many myths persist about traumatic brain injury. Whether through ignorance or by design, the myths may prevent legitimately injured people from receiving the medical care and treatment that they need and deserve.

There are far too many lawyers representing persons surviving TBI who are not able to provide proper representation for the injured person because they fail to recognize that psychiatric consequences of TBI, even though disabling, are not as "serious" as cognitive or physical impairments for a survivor's future earning capacity and worklife expectancy.

Thus, let us examine five persistent and common myths with authoritative answers to be followed with questions that should be addressed either to your own expert or to ask in deposition.

Myth #1 - Loss of consciousness is a pre-requisite for traumatic brain injury.

The typical history indicates that at time of accident and shortly thereafter, the person was comatose for only a very brief period, if at all, and showed practically no retrograde amnesia and little post traumatic amnesia. In Mild Head Injury by Levin, Isenberg and Benton. In Neuropsychiatry of Traumatic Brain Injury, by Silver, Yudofsky and Hales, they indicate that 35% of the people studied in current scientific literature suffered TBI without reported loss of consciousness.

Mr. Wentzel:

Evaluating and challenging traumatic brain injury claims can often be aided with these strategic steps. Begin by evaluating the severity of injury.

Categorization is Crucial

Proper categorization is essential to allow defense counsel to make appropriate decisions about resources and expenses, determine appropriate experts and focus defense efforts. Commonly used criteria for evaluating severity include:

- ◆ Neurological diagnostic studies
- ◆ Loss of consciousness and length of loss of consciousness
- ◆ Loss of memory for events before the accident (retrograde amnesia) and after the accident (anterograde or "post-traumatic" amnesia)

Retrograde amnesia is generally a poor indicator of severity of injury, since even with significant head injuries, there may be little or no retrograde amnesia. Conversely, there is generally a strong correlation between severity of injury and length of post-traumatic amnesia.

The continuum of severity in head injury runs from mild to moderate to severe. Each group has characteristic courses of improvement and outcomes as follows:

Expected Outcomes from TBI

Q: Doctor, would you agree that a person need not lose consciousness or be in a coma to suffer a traumatic brain injury? During your career, have you made diagnosis of TBI for any patients whose hospital record indicated that there was no loss of consciousness?

Myth #2 – *“Mild” or “minor” descriptions of TBI mean insignificant consequences.*

In Closed Head Injuries: A Clinical Sourcebook, Dr. Peter G. Bernad states: “The symptoms this syndrome includes can severely limit a patient’s ability to perform everyday activities and return to a preinjury lifestyle. In some cases, the patient is unable to return to work because of persistent symptom, that may last a long time.”

“The patients sustain organic brain damage that causes problems in attention, concentration, memory and judgment. For the most part they recognize these deficits and are disturbed by them,” according to a 1981 article in Neurosurgery, Vol. IX, #3 by Rimel, Giordano, Barth, Boll and Jane.

Q: Doctor, have you provided or recommended cognitive rehabilitation for someone suffering from a minor or mild brain injury? Doctor, have you actually determined, with one or more of your patients, that they were disabled from competitive employment as a result of the consequences of a minor or mild brain injury?

Myth #3 – *TBI cases are not serious because they are “only psychiatric problems.”*

In the American Psychiatric Press Textbook on Neuropsychiatry, by Yudofsky and Hales, they state: “Psychiatric disturbances associated with frontal lobe injury commonly include impaired social judgment, labile affect, uncharacteristic lewdness, inability to appreciate the effects of one’s behavior or remarks on others, a loss of social graces, a diminution of attention to personal appearance and hygiene and boisterousness.”

“Cognitive, intellectual and emotional problems also appear to be more persistent and socially and vocationally disabling than physical or sensory and motor disabilities,” state authors Dikmen, Reitan and Temkin in Neuropsychological Recovery in Head Injury, Vol. 40.

Q: Doctor, do you agree that a person can develop psychiatric or emotional problems as a consequence of TBI? Would you agree that a person could develop psychiatric problems following TBI, which may persist even though neuropsychological testing is normal?

Myth #4 – *A head strike is a pre-requisite to a TBI diagnosis.*

In the “Traumatic Brain Injury Study” by Dr. Kenneth M. Adams and Steven H. Putnam, for the Michigan Catastrophic Claims Association 1989, they stated: “Deceleration injuries occur when the head itself is moving rapidly, sometimes striking a stationary object causing a rapid deceleration, which usually thrusts the brain forward in the cranium.”

Q: Doctor, during your career, have you made diagnosis of persons with brain injury who reported that they did not strike their head during the traumatic event? Doctor, did you ever tell anyone in this case that a person needed to strike their head in order to suffer a traumatic brain injury?

Myth #5 – *Cognitive impairments identified on neuropsychological testing do not fit any known pattern of cognitive impairments following TBI.*

This statement occurs when the defense neuropsychologist finds cognitive impairments and no other way to explain those impairments. However, Dr. Muriel Lezak, in Neuropsychological Assessment, says: “The behavioral repercussions of brain damage vary with the nature, extent, location and duration of the lesion; with the age, sex, physical condition and psychosocial background and status of the patient, and with the individual neuroanatomical and physiological differences. Not only is the pattern of deficits displayed by one brain damaged person likely to differ from the pattern displayed by another but impairment patterns of patients with similar lesions may also differ.”

Q: Doctor, would you agree that the book Neuropsychological Assessment by Dr. Muriel Lezak is a reliable and authoritative textbook? Doctor, can you tell us what research, literature or information you have that is different from that contained in that book? Doctor, would you agree that the combination of brain damage with cognitive impairments, and with psychiatric consequences, might produce different types of cognitive impairments in different people?

Finally, in many cases involving mild to moderate cognitive impairments following brain injury, the defense will hire someone to testify that the injured person should be able to find some type of job. The issue is actual employability. When approaching cross-exam of a defense expert in TBI cases, be specific about actual occupations and jobs. And remember: the Bureau of Labor Statistics definition of occupational disability is any physical or mental limitations or restrictions in the kind or amount of work an individual may perform.

CNS

Severe

- ◆Diagnostic studies reveal gross neurological abnormalities and/or structural changes
- ◆Extended period of loss of consciousness (several days or weeks)
- ◆RA ranging from several hours to days
- ◆Lengthy PTA (several days to weeks)

Moderate

- ◆Positive findings on diagnostic studies
- ◆Loss of consciousness ranging from 20 min. to hours
- ◆Possible RA (several hours to several days)
- ◆Moderate PTA (24 hours to several days)
- ◆Hospitalized during acute phase and then discharged home or to rehab center

Mild

- ◆Negative findings on diagnostic studies
- ◆Brief loss of consciousness (less than 20 min.)
- ◆Little or no RA
- ◆Brief PTA (less than 24 hours)
- ◆Usually not hospitalized

The severity of the injury will generally determine how the defense will approach a case, what experts will be needed and what roles experts will perform. Thus, your approach may fall into these strategic areas:

*Approaches Based on Level of Severity***Severe**

- ◆Determine how badly plaintiff is injured, what the long-term prognosis is and how to minimize the sympathy factor
- ◆Use medical and neuropsychological experts as consultants, if at all
- ◆Discovery focus will be on treaters: what help is available, what's the prognosis, what psychotherapy and rehabilitation options or adjustments can be made to maximize functioning and thus minimize loss of earning capacity and emotional distress

Moderate

- ◆Focus on how badly plaintiff is really injured
- ◆Outline treatment options and prognosis
- ◆Explore whether some of plaintiff's symptoms are exaggerated or attributable to something else
- ◆Use experts primarily as consultants
- ◆Designate as testifying experts only if significant basis to dispute nature and/or extent of injury

Mild

- ◆In absence of objective evidence of brain injury, i.e., post-concussion syndrome, shift focus to what's really wrong with the plaintiff and what really caused those symptoms
- ◆Explore whether plaintiff's symptoms and behaviors are caused by a pre-existing personality disorder
- ◆Indicate that there is no medical or objectively verifiable evidence of brain injury
- ◆Introduce possibility that there's nothing medically wrong with the plaintiff
- ◆Raise possibility that plaintiff's symptoms and behaviors are caused by life stressors, not the accident
- ◆Raise the possibility that plaintiff's symptoms and behaviors are fictitious and/or exaggerated
- ◆Explore possibility that plaintiff's symptoms and behaviors are caused by a pre-existing medical condition or are

the result of medication

- ◆Use a neuropsychological expert to evaluate testing and opinions of plaintiff's expert, to prepare for cross-exam and possibly conduct independent exam and/or offer rebuttal

Next, Evaluating Potential Malingering

Your next step will be evaluating malingering in mild TBI cases. Malingering is usually defined as the deliberate simulation or exaggeration of an illness or disability to avoid an unpleasant situation or obtain some kind of personal gain.

The criteria for diagnosing malingering are found in the Diagnostic and Statistical Manual of the American Psychiatric Association which states: "The essential feature of malingering is intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs."

Malingering, like severity of injury, can fall along a continuum ranging from mild to severe exaggeration. Tests for malingering can include the Minnesota Multiphasic Personality Inventory, the Million Clinical Multiaxial Inventory or other subjective tests. Lay testimony may frequently be far more effective than expert testimony, however and easier for the jury to understand, i.e., films and surveillance, observations of friends, neighbors or co-workers, etc.

*Cross-exam of the Neuropsychologist
And Other Factors*

The third strategic area is cross-exam of the plaintiff's neuropsychologist. Naturally, a defense perspective will start with examination of credentials and qualifications, specifically asking about experience evaluating malingering or with comparable patients. The next step can be a focus on the lack of scientific basis for the opinion, lack of standardization in assessment methods, conflicting research and studies and emphasis that it's psychology, not medicine.

Another approach can include listing historical factors possibly excluded from assessment such as medical records from the ER, neurological tests, school records, employment evaluations and reliance on self-reports. Inadequate testing can also be examined including absence of tests for malingering and pre-existing mental disorders. Finally, defense may want to explore whether test results were subjective or biased and examine a possible lack of baseline information.

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VOCATIONAL ECONOMICS, INC.

For more information call
800-227-0198
or visit VEI @
www.VocEcon.com

National Headquarters
1 Riverfront Plaza, Suite 2100
Louisville, KY 40202

VE Insight

Send **your** question or issue via fax: 502/589-5428 or submit to: Dee@iglou.com

Quarterly Question: Where can I get more information on traumatic brain injury?
There are excellent resources available; we are pleased to mention these:

Brain Injury Association—Excellent annual conference for attorneys on legal and medical issues relating to traumatic brain injury Every fall—for more details, call: 703-236-6000 or 703-683-6334 or visit the BIA web site: www.biausa.org for conference information and other resources

Kentucky Academy of Trial Attorneys—Often sponsors an annual seminar on traumatic brain injury case development and management

For more information, call: 502-339-8890 or visit their web site www.kata.org

Brain Injury Association of Kentucky – Advocacy, Education, Injury Prevention, Research, Service & Support 1-800-592-1117 or 502-493-0609 www.braincenter.org

Ohio Brain Injury Association – Community Support Network, Helpline, Education, Prevention, Support 800-686-9563 (in Ohio) 614-481-7100 or e-mail: ohio-bia@infinet.com

The Brain Injury Association web site will contain information on all state associations.